ROCKY MOUNTAIN
HEALTH CENTERS PEDIATRICS, P.C.

PEDIATRIC HISTORY

(Please print)

DATE ____________________

PATIENT'S NAME ____
last first middle nickname

BIRTHDATE ____________________ AGE _______ ( ) Male ( ) Female

FAMILY	Name	Age	Education	Occupation	Health	Height	Weight
Father							
Mother							
Brothers							
Sisters							
Others living in household:							

Family intact? ____________________ Patient lives with ____________________

Patient's school (or daycare center) ____________________ Grade ______

Family history *(check if blood relatives - aunts, uncles, brothers, sisters, cousins, and grandparents - have):*

( ) allergies ____________________
( ) asthma ____________________
( ) eczema ____________________
( ) hay fever ____________________
( ) anemia or blood problems ____________________
( ) tuberculosis ____________________
( ) rheumatic fever ____________________
( ) high blood pressure ____________________
( ) heart attack ____________ ( ) under age 55
( ) stroke ____________ ( ) under age 55
( ) death before age 50 other than accident: cause ____________________
( ) neurologic disorder (e.g. epilepsy): specify ____________________
( ) inherited disease (e.g. muscular dystrophy, cystic fibrosis): specify ____________________

( ) diabetes mellitus ____________________
( ) thyroid (goiter, etc.) ____________________
( ) hearing loss ____________________
( ) eye disorder ____________________
( ) lung disease ____________________
( ) liver disease ____________________
( ) kidney or urinary tract disease ____________________
( ) arthritis ____________________
( ) cancer: type ____________________
( ) birth defect ____________________
( ) mental retardation ____________________
( ) psychiatric problems ____________________

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PATIENT'S MAJOR ILLNESSES, ACCIDENTS, AND HOSPITALIZATIONS

DATE ______________ AGE ______ HOSPITAL ____________________

PROBLEM: ____________________

OTHER ILLNESSES	AGE
( ) Roseola	________
( ) Chickenpox	________
( ) German measles (3 day)	________
( ) Measles (10 day) (hard)	________
( ) Mumps	________
( ) Scarlet fever	________
( ) Strep throat	________
( ) Rheumatic fever	________
( ) Infectious mononucleosis (mono)	________

Special x-rays or lab tests ____________________

Accidental poisoning ____________________

ALLERGIES to food or medicine: ( ) yes ( ) no: which ____________________

MEDICINE taken by patient (include vitamins and/or fluoride): ____________________

IMMUNIZATIONS* up-to-date? ( ) yes ( ) no
Any reactions? ( ) yes ( ) no: Specify ____________________

*Please provide record of immunizations for our chart.

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PREGNANCY AND BIRTH

(check items that apply):

( ) high blood pressure
( ) sugar or protein in urine
( ) any infection, including V.D. Specify ____________________
( ) bleeding or spotting problem
( ) taking medicine or drugs
( ) smoking, ______packs per day
( ) drinking alcoholic beverages, amount/day ______

Month you (mother) started seeing a doctor ____________________. Prenatal care where ____________________

Problems in pregnancy ( ) yes ( ) no: specify ____________________

Vitamins with iron taken ( ) yes ( ) no

Pregnancy length ____________________ Length of labor ____________________

TYPE OF DELIVERY: ( ) vaginal ( ) C section

Birth presentation: ( ) head first ( ) breech

BIRTH WEIGHT ____________________ LENGTH ____________________

Baby have any problems in hospital? (includes jaundice, breathing problems, seizures, blueness, etc.) ____________________

Any problems during first month of life? ____________________

DEVELOPMENT (age when first occurred):

Held head up ____________________
Sitting without support ____________________
Walking alone ____________________
Talking: first words ____________________ put two words together ____________________
Toilet trained: bladder ____________________ bowel ____________________

INFANT FEEDING:

( ) Breast-fed ( ) Bottle-fed (Which formula?) ____________________
Whole milk begun at what age? ____________________
Number of ounces per day ____________________
Vitamins? ( ) yes ( ) no: type ____________________
Iron? ( ) yes ( ) no: type ____________________

PRESENT NUTRITION:

Does your child eat 3 balanced meals per day? ( ) yes ( ) no
Does your child eat much junk food? ( ) yes ( ) no
Number of glasses of milk per day ________ Picky eater? ( ) yes ( ) no

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REVIEW OF SYSTEMS

(check ones that are or were a problem and include diagnosis or symptoms):

( ) eye disorders (cross-eyed, infection, etc.) ____________________
( ) ear infections, ( ) hearing problems, ( ) tubes in ears ____________________
( ) nosebleeds: frequency ____________________, age when started ________
( ) sore throats or colds: frequency per year ____________________
( ) croup ____________________
( ) pneumonia ____________________
( ) bronchitis or wheezing: (specify) ____________________
( ) chest pains, ( ) chronic cough ____________________
( ) asthma ____________________
( ) eczema ____________________
( ) skin problems (hives, etc.) ____________________
( ) dental problems ____________________
( ) heart murmur ____________________
( ) heart disease ____________________
( ) colic ____________________
( ) stomach aches: frequency ____________________
( ) poor appetite ____________________
( ) weight loss ____________________
( ) jaundice ____________________
( ) diarrhea: frequency ____________________
( ) constipation: frequency ____________________
( ) black stool, ( ) bloody stool ____________________
( ) bladder infection ____________________
( ) painful urination ____________________
( ) frequent urination ____________________
( ) bed-wetting, ( ) wetting during daytime ____________________
( ) painful periods (menstruation) ____________________
( ) vaginal discharge ____________________
( ) penile discharge or ( ) sores on penis ____________________
( ) anemia ____________________
( ) sickle cell trait or ( ) disease ____________________
( ) g-6 PD deficiency ____________________
( ) easy bruisability or easy bleeding ____________________
( ) joint pain ____________________
( ) loss of consciousness ____________________
( ) dizzy spells ____________________
( ) seizures (check if with fever _____) ____________________
( ) headaches: frequency ____________________
( ) eating paint chips, etc. ____________________