

# FALLBROOK FAMILY HEALTH CENTER, LLC

## PEDIATRIC HISTORY FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Birth weight \_\_\_\_\_ Length \_\_\_\_\_ Delivered by \_\_\_\_\_

Parents' names: \_\_\_\_\_

Parents' Marital status: (circle one)      Married      Divorced      Separated      Never married

List of all those living in household and relationship to patient: \_\_\_\_\_

**PREGNANCY INFORMATION:** (Circle and elaborate)

COMPLICATIONS DURING PREGNANCY: bleeding, infections, toxemia, diabetes, medication use during pregnancy, none

LABOR: breech, prolonged, baby's heart rate slow, none

DELIVERY: C-section, forceps, heavy bleeding, premature, late, none

HOSPITAL STAY: yellow jaundice, infections, feeding problems, none

**FEEDING HISTORY:** Breast \_\_\_\_\_ Formula type \_\_\_\_\_  
Solids (identify) \_\_\_\_\_ Vitamins \_\_\_\_\_  
Fluoride supplement or tap water      yes      no

**ALLERGIES:** Foods \_\_\_\_\_ Medications \_\_\_\_\_  
Other \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**OPERATIONS:**

Type	Date Performed	Hospital	Surgeon

**HOSPITALIZATIONS:**

Diagnosis	Date	Hospital	Physician

**SERIOUS INJURIES OR ACCIDENTS AND DATES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS:** (List Dates)

	#1	#2	#3	#4	#5
DTaP					
Polio					

Measles, Mumps, Rubella (MMR) \_\_\_\_\_ TB Test \_\_\_\_\_  
 BCG \_\_\_\_\_ Other (Typhoid, cholera, small pox) \_\_\_\_\_

**DEVELOPMENTAL:** Age child: Sat up \_\_\_\_\_ crawled \_\_\_\_\_ walked \_\_\_\_\_  
 Toilet trained \_\_\_\_\_ talked in phrases \_\_\_\_\_

**DAY CARE:** Home based \_\_\_\_\_ Center based \_\_\_\_\_

**EXPOSURE TO CIGARETTE SMOKE:** Yes \_\_\_\_\_ No \_\_\_\_\_

**FIREARMS IN HOME:** Yes \_\_\_\_\_ No \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Does your child have, or has he/she ever had: (circle yes or no)

**INFECTIOUS DISEASE**

Chicken pox yes no  
 If yes, when: \_\_\_\_\_  
 HIV/AIDS yes no  
 Sexually transmitted disease yes no

**ENT**

Frequent ear infections yes no  
 Problems with hearing or ears yes no

**ALLERGIES**

Food or environmental allergies yes no

**EYES**

Problems with eyes or vision (acne, eczema, etc) yes no

**RESPIRATORY**

Asthma yes no  
 Frequent bronchitis or pneumonia yes no  
 Recurrent croup yes no  
 Tuberculosis or positive TB skin test yes no  
 Other chronic or serious lung disease yes no

**CARDIAC**

High blood pressure yes no  
 High cholesterol yes no  
 Heart murmur yes no  
 Congenital or acquired heart defect yes no

**HEMATOLOGY**

Anemia or bleeding problem yes no  
 Blood transfusion yes no  
 Cancer yes no

**GASTROINTESTINAL**

Frequent abdominal pain yes no  
 Constipation requiring doctor visits yes no

**GENITOURINARY**

Bladder or kidney infection yes no  
 Bed-wetting (after 5 years old) yes no

**ENDOCRINE**

Thyroid or other endocrine problem yes no  
 Diabetes yes no

**SKIN**

Any chronic or recurrent skin problem yes no

**NEUROLOGIC**

Frequent headaches yes no  
 Convulsions or other neurologic problem yes no  
 Concussion yes no

**PSYCHIATRIC**

Emotional disorder or suicide attempts yes no  
 Behavior disorder (ADHD, ODD) yes no  
 Psychiatric disorder yes no  
 Use of alcohol or drugs yes no

**GENITOURINARY**

(For girls) Has she started her menstrual periods yes no  
 (For girls) Are there problems with her periods yes no

Other  yes  no

Please explain any yes answers: \_\_\_\_\_

**FAMILY HISTORY**

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
<b>Father</b>				
<b>Mother</b>				
<b>Brothers/sisters</b>				
1.				
2.				
3.				
4.				

Has any blood relative ever had:	YES	NO	Relationship (circle what applies)	Age at Onset
Cancer Type of Cancer:			Grandmother/grandfather/maternal/paternal/other relative	
Heart trouble			Grandmother/grandfather/maternal/paternal/other relative	
Diabetes			Grandmother/grandfather/maternal/paternal/other relative	
Stroke			Grandmother/grandfather/maternal/paternal/other relative	
High blood pressure			Grandmother/grandfather/maternal/paternal/other relative	
Thyroid problem			Grandmother/grandfather/maternal/paternal/other relative	
Anesthesia or malignant hyperthermia problems			Grandmother/grandfather/maternal/paternal/other relative	
Bleeding or blood clotting problems			Grandmother/grandfather/maternal/paternal/other relative	
Mental illness			Grandmother/grandfather/maternal/paternal/other relative	
Other			Grandmother/grandfather/maternal/paternal/other relative	