MY KID'S DOC - SOUTHFIED, PLLC

PEDIATRIC HEALTH HISTORY

PATIENT'S NAME _____ D.O.B. _____

A HEALTH CARE STATUS

1. Where has your child gone for check ups until now? _____
2. What is the date of your child's last checkup? _____
3. What is the date of your child's last dental checkup? _____
4. Is your child under treatment now for an illness or medical condition? Yes No
   If yes, for what? _____
   With whom? _____
5. Has your child had allergic reactions to any medications food or bee stings? Yes No
6. Has your child had reactions to any immunizations? Yes No
   If yes, please list: _____
7. Any hospitalizations other than birth? Yes No
   If yes, please list: _____
8. Does your child take any medications regularly, including over the counter medications such as Tylenol or vitamins? Yes No
   If yes, please list: _____

B. PREGNANCY AND BIRTH

1. Mothers age at birth of this child _____
2. Did mother have any illnesses during this pregnancy Yes No
3. Did mother use any medications other than vitamins / Yes No
4. Was the baby born on time? Yes No
5. What was the baby's birth weight? _____
6. Did the baby have any trouble starting to breathe? Yes No
7. Did the baby have any trouble in the hospital? Yes No
   (Jaundice, infections, other?) What kind? _____

C. FAMILY HISTORY

1. Are the child's parents in good health? Yes No
2. Circle any diseases that this child's parents, grandparents brothers, sisters, aunts and uncles have had: Anemia Asthma Allergies Diabetes AIDS High Blood Pressure Heart Trouble Tuberculosis Mental Illness Cancer Drug Problems Alcohol Problems Inherited Illness
   Other _____
3. List general health, age and sex of brothers and sisters
   _____
   _____
   _____
4. Have any of your children died? Yes No

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problems during the first 3 months of life? Yes No
4. Do any foods disagree with your child? Yes No
5. Is/was your child **Breast** or **Bottle Fed** or **Both?** (circle)
6. If still on formula which one do you use? _____
7. Does your child take vitamins? Yes No

LIST ANY OTHER QUESTIONS FOR THE DOCTOR

E. REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? Yes No
2. Has your child had any eye or vision problems? Yes No
3. Has your child had any problems with teeth? Yes No
4. Does your child have frequent colds or sore throats? Yes No
5. Is there asthma, pneumonia or a recurrent cough? Yes No
6. Does your child have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems _____

F. DEVELOPMENT / BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child say any words by the time he/she was 1 1/2 years old? Yes No
4. How does your child compare to other children of his or her age? _____
5. Does your child have trouble sleeping? Yes No
6. What grade is your child in? _____
7. Does your child get along with other children? Yes No
8. Circle if your child has any of the following: Nail Biting Thumb Sucking Bed Wetting Problems with Toilet Training Bad Temper Hyperactivity Nightmares Speech Problems Problems with Discipline Other

G. SAFETY / ENVIRONMENT

1. Do you live in a private house, apartment, mobile home other? (circle)
2. Do you know the hottest temp of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor where you live? Yes No
4. Does your child always use a seat belt / car seat in a car? Yes No
5. Do you forbid smoking in your house? Yes No
6. Is your home regularly inspected for health hazards such as peeling paint, insects, rats or mice? Yes No
7. Does your child wear a helmet when riding a bike? Yes No
8. Do you have any firearms in the home? Yes No
9. Have any of the child's caregivers been trained in CPR? Yes No
10. Do you have Syrup of IPECAC in your home? Yes No
    And the number for POISON CONTROL? Yes No
11. Kids under 10 never cross streets alone? Yes No
12. Kids are always supervised in or near water? Yes No
13. Are children protected against falls from windows, stairs, furniture and playground equipment? Yes No
14. Household cleaners, medicines and vitamins are stored out of young kids' reach? Yes No
15. Our home has emergency numbers near telephones and first aid supplies. Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

If yes, please give immunization record to nurse with this form.

NAME OF PERSON COMPLETING FORM: _____ DATE _____

RELATIONSHIP _____ PHYSICIANS SIGNATURE _____ DATE _____