PINEVILLEPEDIATRICS

CHILD'S NAME:_____ AGE:_____ DATE OF BIRTH:_____
CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: _____
What is the primary reason you are seeing the doctor today: _____
PHARMACY NAME AND ADDRESS_____
MEDICATION ALLERGIES:_____None _____Penicillin_____ Sulfa Other:_____
What type of reaction did your child have? _____

PERSONAL MEDICAL HISTORY:
Please check(X) if your child has had any of the following medical problems:

____ADD/ADHD	____Bronchitis	_____Reflux disease	___Recurrent ear
____Abdominal pain	____Chicken Pox	_____Headaches	infections
____Acne	____Concussion/closed	____ Hearing problems	___Urinary tract
____Allergic rhinitis	head injury	____Heart murmur	infection
____Allergies	____Constipation	_____Migraines	___ Turner's Syndrome
____Anemia	____Diabetes	_____Pneumonia	____Down's Syndrome
____Asthma	____Eczema	_____Kidney Infection	____Fracture
____Congenital heart disease		_____Bronchiolitis	

Other problems (specify):_____

SURGICAL HISTORY:
Please circle or write in any surgeries or procedures which your child has had. Indicate the year of the procedure in the space.

____Appendectomy	____Surgery to repair	____Adenoidectomy	____Umbilical hernia repair
____Inguinal hernia	a broken bone	____PET placement	____Circumcision
Repair	____Tonsillectomy	____Lymph node	____Hypospadias repair
		Biopsy/excision	

Other surgeries (specify type and year):_____

FEMALE HISTORY:
Age at 1st period: ____ First day of most recent period: _____ Has not yet had menses:____
Currently pregnant? _____Yes ____No ____possibly

BIRTH HISTORY:
Please indicate any medical problems during pregnancy: _____
Delivery by: ___ C-section ___ vaginal delivery ____vacuum/ forceps vaginal delivery
Birth weight: _____ Birth length: _____
Please indicate any medical problems during the newborn period: _____

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CHILD'S NAME_____

FAMILY HISTORY: Please indicate if your child has a family history of any of the following:

Diagnosis	**Family member(s)**	**Age at onset**	**Living?**
ADD/ADHD	_____	_____	_____
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Birth Defects	_____	_____	_____
Cancer, type: _____	_____	_____	_____
Heart Disease	_____	_____	_____
Hip Dysplasia	_____	_____	_____
Deafness	_____	_____	_____
Depression	_____	_____	_____
Developmental Delay	_____	_____	_____
Diabetes	_____	_____	_____
Eczema	_____	_____	_____
Genetic Disorder	_____	_____	_____
Hemoglobinopathy	_____	_____	_____
Elevated Cholesterol	_____	_____	_____
High Blood Pressure	_____	_____	_____
Learning Disability	_____	_____	_____
Mental retardation	_____	_____	_____
Migraines	_____	_____	_____
Obesity	_____	_____	_____
Scoliosis	_____	_____	_____
Seizure Disorder	_____	_____	_____
SIDS	_____	_____	_____
Lazy eye	_____	_____	_____
Thyroid disease	_____	_____	_____

Other genetic diseases or child hood illnesses (please specify):_____

SOCIAL HISTORY:

Do any household members smoke? ____Yes _____No Smoke outside only? ___Yes ___No
Childcare providers: (specify who and number of days per week):_____
Uses bike/skating helmet: ____Yes ____No
Car restraints: _____Car seat: face rear ____Car seat: face front ____Booster ___Seat belt ___None
Carbon monoxide detector: ___Yes ___No Smoke detector: ___Yes ___No
Radon in home: ___Yes ___No ___Untested ___Treated Firearms in the home: ___Yes ___No
Pets/animals at home: ___Yes ___No Type of animals:_____
School Name: _____ Likes school? ___Yes ___No
Grade in School: _____ Truancy? ___Yes ___No
Grades earned: _____ Child's educational goals? _____
Learning disability? ___Yes ___No Special needs? ___Yes ___No
Gifted program? ___Yes ___No
Performing: ___Below grade level ___At grade level ___Above grade level
Has your child repeated any grades? ___Yes ___No Grade(s) _____ Why?_____
Has your child ever been suspended or expelled? ___Yes ___No Why?_____
Takes naps: ___Yes ___No Exercise/sports: ___hours per day Type of exercise/sport: _____
Sleeps with parents: ___Yes ___No Sleeps through the night: ___Yes ___No
Has TV in bedroom? ___Yes ___No TV/computer games: ___hours per day