

## PEDIATRIC MEDICINE, P.A.

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### HISTORY SHEET

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Referred By: \_\_\_\_\_

### CURRENT PROBLEMS/CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PAST HISTORY:

Hospitalizations/Surgery, date and diagnosis: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies to medication: \_\_\_\_\_

Check if child has had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Asthma          | <input type="checkbox"/> School problems    |
| <input type="checkbox"/> Measles               | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Allergies to foods |
| <input type="checkbox"/> Recurrent tonsillitis | <input type="checkbox"/> Urine Infection | <input type="checkbox"/> Febrile Seizure    |
| <input type="checkbox"/> Ear Infections        | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> RSV                |

### BIRTH HISTORY:

Birth weight: \_\_\_\_\_ Feeding: Breast \_\_\_\_\_ Bottle \_\_\_\_\_

Problems as a newborn: \_\_\_\_\_

Problems in pregnancy or delivery: \_\_\_\_\_

Smoking during pregnancy?  Yes  No

Alcohol during pregnancy?  Yes  No

Medications during pregnancy? \_\_\_\_\_

### GROWTH and DEVELOPMENT:

Age at which sat: \_\_\_\_\_ Walked alone: \_\_\_\_\_ Spoke single word: \_\_\_\_\_ Spoke in sentences: \_\_\_\_\_

School grade: \_\_\_\_\_ Regular class \_\_\_\_\_ Special \_\_\_\_\_

Problems/Concerns \_\_\_\_\_

Does anyone smoke in the home?  Yes  No

Does child attend daycare?  Yes  No

Languages spoken in the home: \_\_\_\_\_

