THOUSAND OAKS PEDIATRICS
PEDIATRIC HISTORY FORM

Child's Name_____ **BD**_____ **Age**_____ **Today's Date**_____

A. BIRTH HISTORY

(Circle any that apply and give details)

1. *Pregnancy:* Planned, Unplanned, Problems Conceiving, IVF, Drug Use, Alcohol, Tobacco, Medications, Illness, Injury, High Blood Pressure, Diabetes_____

2. *Birthplace*:_____

3. *Labor:* Normal, Premature (# weeks) _____ Late, Induced, Spontaneous, C-Section (why):

Duration of Labor _____

4. *Birthweight* _____ *Length*_____
*Apgar Scores*_____

5. *Problems after birth*: None, Breathing, Apnea, Infection, Feeding Problems, Jaundice, Seizures, Colic _____

6. If baby was in NICU, for how long?_____

B. PAST MEDICAL HISTORY

1. How is your child's general health? _____
2. *Hospitalizations & Surgeries* (when, where, why)

3. *Serious Injuries*_____

4. **Allergic Reactions (to drugs, food, etc)**

5. *Immunizations* (any routine shots that your child has **not** had)_____

6. *List serious illness, medical diagnosis, or chronic illness:*_____

7. *Current medications*_____

8. *Systems Review*: Has your child had any of the following?
(Circle all that apply and give details)
Headaches, frequent ear infections, wears glasses, frequent red eyes, eyes cross, frequent sinus infections, nasal allergies, frequent sore throats, pneumonia, frequent cough, nighttime cough, asthma, frequent croup, chest pain, heart murmur, irregular heart beat, frequent stomach aches, heartburn, diarrhea, constipation, blood in stool, urinary problems, bed wetting, urinary infection, blood in urine, swollen joints, back pain, frequent skin rash, seizures, weakness, anemia, bleeding problems, Sleep problems, nightmares, night terrors, snoring, sleep apnea, anesthesia problems, chicken pox, scarlet fever, roseola,

C. DEVELOPMENT

1. *Milestones:* Age when your child first:
Sat_____ Crawled_____ Walked_____
Few Words_____ Phrases_____
Toilet Trained- Urine_____ -Bowel _____
Any concerns about development?_____

2. *School:* Grade Level_____
Avg. Grades_____
Special Education? _____
Special services like OT, PT, Speech?_____

3. *Any behavior problems?*

4. *Routines:*
Feeding Problems_____
Special Diet_____
Vitamins, Fluoride _____
Nutritional supplements _____
Habits _____
Sports _____
Hobbies _____