Westchester Park Pediatrics
WPP

PATIENT HISTORY

Patient's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to child: _____

PREGNANCY & BIRTH HISTORY

Where was your child born? _____

Problems during pregnancy: _____

Mother's medication during pregnancy: _____

Type of Delivery: ☐ vaginal ☐ C-section, reason: _____

Number of weeks Gestation: _____ Birth Weight: _____

Problems during delivery or newborn period: _____

PAST HISTORY:

Has your child ever been diagnosed with or treated for any of the conditions below?

☐ Asthma/Reactive Airways	☐ Anemia	☐ Migraines
☐ Wheezing or Bronchiolitis	☐ Lead poisoning	☐ Seizures
☐ Pneumonia	☐ Bleeding/Clotting disorder	☐ Concussion
☐ Sleep Apnea	☐ Heart Murmur	☐ Broken Bones
☐ Recurrent Ear Infections	☐ High Blood Pressure	☐ Vision/Hearing Problem
☐ Recurrent Strep Throat	☐ High Cholesterol	☐ Developmental Delays
☐ Recurrent Sinus infections	☐ Other Heart Conditions	☐ Speech Delay or Disorder
☐ Food allergies	☐ Urinary Tract Infections	☐ ADHD/ADD
☐ Environmental Allergies	☐ Constipation	☐ Other Learning Disorder
☐ Eczema	☐ Irritable Bowel Syndrome	☐ Autism Spectrum Disorder
☐ Other Skin Conditions	☐ Celiac Disease	☐ Depression/Anxiety
☐ Thyroid Disease	☐ Inflammatory Bowel Disease	☐ Alcohol/Drug/Tobacco Use
☐ Diabetes	☐ Failure to Thrive	☐ Other Medical Conditions
☐ Growth Hormone Deficiency	☐ Gastroesophageal Reflux (GERD)	

Please explain any other conditions _____

List any specialist your child sees and the reason: _____

Has your child ever had surgery? Explain: _____

Has your child ever been hospitalized? Explain: _____

MEDICATIONS:

Is your child allergic to any medications or vaccines? ☐ No ☐ Yes, please list: _____

Prescription medications your child takes: _____

Over-the-counter medications: _____ Vitamins/Supplements:

_____

Westchester Park Pediatrics
WPP

SOCIAL HISTORY

Is the child yours by ☐ Birth ☐ Adoption ☐ Step-child ☐ Other

Who does your child live with? ☐ Mom ☐ Dad ☐ Step-Parent ☐ Grandparents ☐ Siblings ☐ Other _____

Number of siblings_____

Child's parents are: ☐ married/together ☐ separated, shared custody ☐ separated, sole custody ☐ other

Does anyone in the household smoke? ☐ No ☐ Yes

Are there any guns in the home? ☐ No ☐ Yes

FAMILY HISTORY:

Has anyone in your child's family ever had any of the following conditions?

	Mother	Father	Sibling	Grandparent	Explain
Asthma	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Eczema	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Blood Disorder	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Born with heart disease	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	
Autoimmune Disease	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	
Inflammatory Bowel Disease	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	
Learning disorder	☐	☐	☐	☐	
ADD/ADHD	☐	☐	☐	☐	
Developmental Delay	☐	☐	☐	☐	
Depression/Anxiety	☐	☐	☐	☐	
Alcohol or drug use	☐	☐	☐	☐	
Other Conditions	☐	☐	☐	☐	

Please explain any other conditions:

Physician signature: _____ Date:_____