PATIENT HISTORY

CHILD'S NAME_____**D.O.B**_____**SEX**_____

REFERRED BY _____ **PREVIOUS PEDIATRICIAN** _____

PREFERRED PHARMACY_____

DID MOTHER HAVE ANY INFECTIOUS ILLNESS DURING PREGNANCY? (i.e. German measles (rubella), flu, bladder or kidney infection)
Type of Infection: _____ **Month of pregnancy**_____
Medication(s) Given:_____

Did mother take any medications during pregnancy?
___ **Vitamins** ___ **Laxatives** ___ **Iron** ___ **Antibiotics** ___ **X-Rays** ___ **Aspirin/Tylenol**
___ **Prescriptions** ___ **Cigarettes** ___ **Alcoholic Beverages** ___ **Birth Control Pills**
___ **Other over-the-counter drugs** ___ **Marijuana or other drugs**

Were there any complications of the labor or delivery? (i.e. prolonged labor, prematurity, fetal distress, c- section, forceps, difficulty in getting baby to breathe)
_____

Birth weight _____ **Length** _____ **Did infant stay longer than the mother? Yes No**
If yes, why? _____

HOSPITAL OF BIRTH (Name, City, State) **OBSTETRICIAN & LOCATION**
_____ _____

ILLNESSES

Have there been any hospitalizations?	**_____Yes**	**_____No**
Have there been any medical problems?	**_____Yes**	**_____No**
Any childhood illnesses? (i.e. chicken pox, measles etc.)	**_____Yes**	**_____No**
Fracture or other injury?	**_____Yes**	**_____No**

If yes, please explain:_____
_____

PUBERTY
Any signs of breast development, adult body odor, voice change, adult hair pattern, periods? ___Yes ___No

Medications:_____

Allergies:_____

Diet:_____

RISE & SHINE PEDIATRICS
FAMILY HISTORY
Please circle or write in medical conditions in biological parents, siblings, aunts, uncles, cousins or grandparents.

Family Member

SKIN: eczema, psoriasis, ichthyosis, other_____ _____
EYES: blindness, cataracts, lazy eye, other_____ _____
EARS: deafness, infections, other_____ _____
NOSE/THROAT: sinus, tonsillitis, other_____ _____
MOUTH: cleft palate, diabetes, other_____ _____
LUNGS: asthma, cystic fibrosis, other_____ _____
HEART: murmurs, heart attack, high blood pressure, other_____ _____
_____
STOMACH/BOWEL: ulcers, colitis, lactose intolerance, other_____ _____
_____
KIDNEY/BLADDER: congenital abnormalities, infections, kidney stones, other
_____ _____
BONE or JOINT DISEASE: osteoarthritis, rheumatoid arthritis, knee issues, other
_____ _____
NUEROLOGICAL: seizures, paralysis, strokes, ADD/ADHD, autism, other
_____ _____
CANCER (type)_____ _____
DEVELOPEMENTAL PROBLEMS_____ _____
PSYCHIATRIC CONDITIONS: bipolar disorder, schizophrenia, other_____ _____
_____
OTHER:_____ _____

SOCIAL HISTORY (fill-in blank/circle one)

Childcare providers:_____

Do any household members smoke? Yes No If yes, (circle one) inside outside both
Smoke detector? Yes No Carbon monoxide detector? Yes No Firearms in the home? Yes No
Guns are locked & kept separate from ammunition? Yes No

Uses bike/skating helmet? Yes No Pets/animals in the home? Yes No
School name _____ **Grade**_____
Grades earned_____ **Learning disability? Yes No Special needs? Yes No**
Performing: _____Below grade level _____At grade level _____Above grade level
Has your child repeated any grades? Yes No Grades? _____
Why?_____
Has your child ever been suspended or expelled? Yes No If so, why?_____
Exercise/sports ____ hours/day Type of exercise/sport: _____

Sleeps with parents? Yes NoSleeps through the night? Yes No TV in bedroom? Yes No

TV/computer games _____hours/day