Pinehurst Family Care Center, P.A.

Initial Pediatric Assessment

Child's Name: _____ Nickname: _____DOB:_____ Age: _____

My Name/Relation: _____ Today's date: _____

If parents do not live together, what is custody/guardian status? _____

Birth weight _____ Was baby full term? Y N (circle) – if no, how many weeks early? _____

Did mother use alcohol, drugs, or smoke during pregnancy? Y N (circle)-

if yes, list: _____

Type of Delivery? Vaginal C-section (circle) –

if C-section, reason? _____

Complications at birth (e.g. jaundice, low sugar, NICU stay)?

Details

_____

Maternal problems during pregnancy? Details

_____

Is your child up to date on their vaccines? Y N Unsure (circle) ---

please provide copy of shot dates

Do you have particular concerns about any or all vaccines you would like to discuss? Y N (circle)

Has your child been diagnosed with any medical problems? Y N

List: _____

_____

Has your child been hospitalized since birth? Y N

List date and reason: _____

_____

Has your child had any surgeries? Y N

List date and operation(s): _____

Has your child had any serious accidents/injuries/fractures? Y N

List: _____

Is your child **allergic** to any medications? Y N

List med and reaction: _____

Is your child **allergic** to foods or bee stings? Y N

List: _____

Does your child take medication (OTC or Rx) regularly? Y N

List: _____

Does your child have:		Details
Developmental problems?	Yes No	
Asthma?	Yes No	
Seasonal allergies?	Yes No	
Allergy testing?	Yes No	
Diabetes?	Yes No	
Problems with vision?	Yes No	
Problems with hearing?	Yes No	
Heart murmur/problems?	Yes No	

Bladder/kidney problems? Yes No

Chronic GI symptoms? Yes No

Epilepsy/seizures? Yes No

(Girls) Started periods? Yes No When?

Exposure to smoker? Yes No Details?

Other members of household:

Name	Age	Relationship to patient	Health problems

Any other blood relatives (back to grandparents) have/had any chronic medical problems? List: