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CHILD AND ADOLESCENT HISTORY

Patient's name: _____ DOB: _____ Sex: ☐ M ☐ F

Parent's name: _____

Is your child having medical problems? ☐ Yes ☐ No If yes, please list: _____

_____

Onset of symptoms: _____ Medications taken for this: _____

_____

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

_____

MATERNAL AND NEW BORN HISTORY

Pregnancy: ☐ High blood pressure, ☐ Infections, ☐ Bleeding, ☐ Other _____

Newborn: ☐ Breast, ☐ Formula, ☐ Multiple formula changes, ☐ Colic, ☐ Feeding problems, ☐ Recurrent vomiting,

☐ Recurrent diarrhea, ☐ Blood in stools, ☐ Slow weight gain, ☐ Jaundice

Length of hospital stay: _____ Other: _____

Birth: Baby was, ☐ full term, ☐ premature, Birth weight: _____

Delivery: ☐ Vaginal, ☐ Caesarean Section, Was labor difficult of prolonged? ☐ Yes, ☐ No

Hospital of birth: _____ Social History: Who lives with the child? _____

What medicines does your child take every day? _____

Present medications & their dosages: _____

_____

List all of the past surgeries and their dates for the child: _____

_____

ILLNESS/PROBLEMS		
☐ Allergies	☐ Blood in sputum	☐ HIV
☐ Allergy shots	☐ Diabetes	☐ School problems
☐ Alcohol or drug abuse	☐ Drug allergies	☐ Seizures
☐ Anemia or blood disorder	☐ Ear tubes	☐ Smoker
☐ Cancer	☐ Eczema	☐ Stomach/intestinal problems
☐ Cholesterol problems	☐ Emotional/behavior problems	☐ Trauma: broken bones, sutures,
☐ Chronic cough	☐ Frequent respiratory infections	loss of consciousness, etc.
☐ Recurrent fever	☐ Growth problems	☐ Tuberculosis
☐ Weight loss	☐ Hereditary problems	
☐ Night sweats	☐ High blood pressure	

Other medical problems:

_____

_____

FAMILY HISTORY:

Does any family member have?

Diabetes: ☐ Yes, ☐ No, Relationship: _____

High blood pressure: ☐ Yes, ☐ No, Relationship: _____

Cancer: ☐ Yes, ☐ No, Location: _____ Relationship: _____

Is the child current on immunizations? ☐ Yes, ☐ No

**** PLEASE PROVIDE RECORDS AND DATES FOR ALL IMMUNIZATIONS****

Immunizations	Date	Immunizations	Date
Hepatitis B		OPV/IPV	
Hepatitis B		OPV/IPV	
Hepatitis B		OPV/IPV	
DTP/DTaP/DT/Td		OPV/IPV	
DTP/DTaP/DT/Td		MMR	
DTP/DTaP/DT/Td		MMR	
DTP/DTaP/DT/Td		Measles (Sarampion)	
DTP/DTaP/DT/Td		Varicella (Chicken pox)	
Hib		Hepatitis A	
Hib		Hepatitis A	
Hib			
Hib			
Pneumococcal			

Have you had chicken pox: ☐ Yes ☐ No If yes, date of disease:_____

Name_____ Date_____