DV PEDIATRICS "Where Kids Count"

CHILD MEDICAL HISTORY: 6 Months or Older

Patient Name _____ **Date of Birth** _____

Adopted ☐ Yes ☐ No
Fostered ☐ Yes ☐ No

Where was your child born? _____

BIRTH HISTORY
Was your child a full term baby? (circle one) ☐ Full Term ☐ Early ☐ Late
☐ Vaginal Birth ☐ C-Section
Birth Weight Lbs. Oz.
Were there any complications with the pregnancy? ☐ Yes ☐ No If yes please explain:
Did your child have any problems right after birth? ☐ Yes ☐ No If yes please explain:

DEVELOPMENTAL HISTORY	**No**	**Yes**	If Yes - explain
Are you concerned about your child's physical development?			
Are you concerned about your child's attention span?			
Has he/she failed or repeated a grade?			
How is your child's behavior in school?			
What kind of grades does he/she make in academic subjects?			
Is he/she in a special or resource classes?			
When did your child: Sit up mos. Crawl mos. Walk mos.			
First sentence (age) Toilet trained (age)			

SOCIAL HISTORY	**No**	**Yes**	**Details**
Lives with both mother and father in same house.			
Non-intact home – who has primary physical custody?			Lives with?
Does non-custodial parent have visitation rights?			
Are there siblings who live in same house?			
Are there pets in the home?			
Does your child ride in a car seat or wear a seatbelt all of the time?			
Does your child wear a bike helmet?			
Does anyone in your home smoke?			
Does your child drink caffeinated soda, coffee, or tea?			How Much?
Is there a gun in your home?			
If yes, is it unloaded and stored in a locked cabinet?			
Do you have a pool?			
If yes, is then pool enclosed by a 4 sided fence?			
Are you concerned that your child is using drugs or alcohol?			
Are you concerned that your child is sexually active?			
How old is the home/apartment you live in?			
Does your home have smoke detectors?			
Does your drinking water have fluoride? ie. City Water			
When was the last time your child saw the dentist?			

Patient Name:_____

	No	Yes	Details
Has your child ever been physically hurt by an adult?			
Have you or are you planning on traveling outside the US?			
Has anyone visited you form a foreign country?			
Does anyone in close contact with your child have HIV/Aids or use IV drugs?			
Has anyone in close contact with your child been in prison, institutionalized or homeless in the last 2 years?			
Number of school absences in the last year?			# of Days?

MEDICATIONS: (Prescription; Over The Counter; Vitamins; Herbs; Etc.)			
Drug Name	Dose	Drug name	Dose

Please check if your child has/had problems with the following:			
□ Anemia	□ Reactive Airways	□ Bedwetting	□ Serious injuries
□ Seizures/Convulsions	□ Wheezing	□ Sleep	□ Broken bones
□ Headaches	□ Abdominal pain	□ Hay fever/allergies	□ Alcohol use/abuse
□ Attention	□ Persistent diarrhea	□ Chronic ear infections	□ Drug use/abuse
□ Behavior	□ Constipation	□ Sinusitis	□ Tobacco use/abuse
□ School	□ Nausea/vomiting	□ Hearing problems	□ Depression
□ Speech	□ Stool accidents	□ Dental problems	Other (Please list)
□ Pneumonia	□ Menstrual problems	□ Vision problems	□
□ Tuberculosis/TB	□ Kidney infections/UTI	□ Crossed/lazy eye	□
□ Asthma	□ Weak urine stream	□ Skin diseases	□

PATIENT ALLERGIES: □ None (If yes, list name and type of reaction)			
Allergy	**No**	**Yes**	**Reaction/Type**
Medications (list)			
Foods (list)			
Insects (list)			

OTHER	**No**	**Yes**	
Has your child ever been hospitalized?			
If yes list dates, location, reason			
Has your child ever had surgery?			
If yes list dates, location, reason			
Dos your child see any specialists? (list)			

Patient Name:_____

FAMILY HISTORY: Have any of the child's parents, grandparents or siblings had any of the following:									
Illness/Condition	**No**	**Yes**	**If Yes – Please check which biological Parent**						
						Maternal		**Paternal**	
			Mom	**Dad**	**Sibling**	**GM**	**GF**	**GM**	**GF**
Anemia									
Anxiety Disorder/Depression									
Asthma									
Bleeding Disorders									
Cancer (type)									
Diabetes									
Drug or Alcohol Abuse									
Elevated Cholesterol									
Epilepsy or Convulsions									
Gastrointestinal Disease/Disorder									
Glaucoma									
Hay fever/Nasal Allergies									
Hearing Disorder									
Heart Disease									
High Blood Pressure									
Hip problems from Childhood									
Immunity Disorder									
Kidney Reflux									
Lazy Eye/Crossed eyes									
Liver Disease									
Mental Illness									
Neurological Issue Incl ADD/ADHD									
Strokes									
Thyroid Disorder									
Vision Disorder									
Other Issues:									

GYNECOLOGIC/OBSTETRIC HISTORY (if applicable – patient's, not mother)			
	No	**Yes**	**Date/Details**
Have Periods?			Date Onset
			Frequency
			Length
Ever have breast exam?			Date Last exam
Ever have an LMP?			Date Last LMP
Ever have a PAP?			Date Last PAP
On Birth Control?			Method?
Any Pregnancies?			
Any Births?			
Any Miscarriages?			

Do you have any concerns regarding your child's health we need to know?

_____ _____

Signature of Parent/Guardian Date