DV PEDIATRICS "Where Kids Count"

CHILD MEDICAL HISTORY: Birth To 6 Months

Patient Name _____ **Date of Birth** _____

Adopted ☐ Yes ☐ No
Fostered ☐ Yes ☐ No

Where was your child born? _____

Birth Weight:_____lb_____oz Birth Length:_____inches

NEWBORN HISTORY – while in hospital	**No**	**Yes**	**If YES - explain**
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Got vitamin K and / or eye ointment			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening labwork (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
First bowel movement after 24 hours?			
Heart Murmur			
Breathing problems			
Needed antibiotics while in nursery			
Other issues:			
MOTHERS PRENATAL HISTORY	**No**	**Yes**	**If Yes - explain**
Was this an assisted conception (had to have help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
When did you start prenatal care?			How many weeks?
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before born?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Did you take prescription medicines while pregnant?			
Was the baby breech?			
Other Issues:			

Patient Name:_____

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?			
Does anyone in your home smoke?			
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?			
How old is the home/apartment you live in?			Years
Does your home have smoke detectors?			
Does your drinking water have fluoride?			
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?			

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

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

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

Patient Name:_____

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)			

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:									

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