PREFERRED PEDIATRICS OF LEE'S HILL

Patient Name ___________________________ Birth Date _________ Sex _____
Mother's Name _________________________ Age ________ Occupation _______
Father's Name _________________________ Age ________ Occupation _______
If the adults in the household work outside the home, what childcare arrangements are made for this child?
____

A. Pregnancy and Birth: (circle "no" or "yes" or leave blank if uncertain)

1. Did the mother have any illness during pregnancy? No Yes
2. Were any medications other than vitamins and iron taken during the pregnancy? No Yes
3. Was the baby born on the calculated due date? No Yes
4. What was the birth weight? __________
5. Did the baby have any trouble starting to breathe? No Yes
6. Did the baby have any trouble while in the hospital? No Yes
   (jaundice, infection, other?)

B. Past Medical History: (circle "no" or "yes" or leave blank if uncertain)

1. Where has your child gone for check ups until now? ____________
2. Date of child's last check up? ____________
3. Date of last dental checkup? ____________
4. Please circle if your child has had allergic reactions to any medications, food, insect bites or immunizations? No Yes
5. If there were any hospitalizations other than birth, please list: ________
6. If the child has had any serious injuries, please list: ________________

C. Family History:

1. Are the child's parents both in good health? No Yes
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts or uncles have/had: anemia, asthma, allergies, diabetes, high blood pressure, heart pressure, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, cancer, AIDS, or learning disabilities.
3. List age, sex and general health of siblings: ______________________
4. Have you had any of your children pass away? No Yes

D. Feeding and Nutrition:

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Were there severe colic or any unusual feeding problems during the first 3 months? No Yes
4. Do any foods seem to disagree with him/her? No Yes
5. For the first 6 months, was he/she (is he/she) breast or bottle fed? ___________
6. If still on formula, which formula do you use? ___________
7. Does he/she take vitamins or fluoride? ___________

(OVER TO COMPLETE)

E. Review of Systems:

Question		
1. Has your child had frequent ear infections?	No	Yes
2. Any eye/sight problems?	No	Yes
3. Has he/she had any problems with teeth?	No	Yes
4. Does he/she have frequent colds or sore throats?	No	Yes
5. Is there a history of asthma, pneumonia or recurrent cough?	No	Yes
6. Does he/she have a heart murmur or any heart problems?	No	Yes
7. Any problems with urination, diarrhea or constipation?	No	Yes
8. Have there been any convulsions or other problems with the nervous system?	No	Yes
9. Any eczema, hives or other skin conditions?	No	Yes
10. Has your child ever been anemic?	No	Yes

11. Please list any other medical problems: ________________________

F. Development/Behavior

Question		
1. At what age did your child sit alone?	___________	
2. At what age did he/she walk alone?	___________	
3. Did he/she say any words by age 18 months?	No	Yes
4. Does he/she have any trouble sleeping?	No	Yes
5. What grade is he/she in?	___________	
6. Has he/she had any trouble in school?	No	Yes
7. Does he/she get along well with other children?	No	Yes

8. Please circle if your child has had any of the following problems with toilet training, bad temper, hyperactivity, nightmares, speech or discipline.

G. Safety and Environment

Question		
1. Is your water heater set at 120 degrees Fahrenheit?	No	Yes
2. Is there a working smoke alarm on each floor of your house?	No	Yes
3. Does your child always use a car seat or seat belt?	No	Yes
4. Are there any smokers in your home?	No	Yes
5. Are there any guns in your home?	No	Yes
6. Does your child always wear a bike helmet when riding his/her bike?	No	Yes