READING PEDIATRICS

PEDIATRIC PATIENT INFORMATION

COMPLETE ONE PER CHILD

Patient Name: _____ **Date of Birth:** _____

Name of Parent(s): _____ **Home Phone:** _____

Address: _____ **City/State/Zip:** _____

Parent Employer: _____ **Work Phone:** _____

Patient's Sex: ( )Male ( )Female

Previous Primary Care MD:

Pregnancy and Birth:

Mother's age at Birth: _____
Father's age at Birth: _____
Baby's birth weight: _____
Was baby on time? ( ) Yes ( ) No
Type of delivery: ( ) Vaginal ( ) Cesarean
Number of days baby stayed in hospital after birth: _____

Check if mother had any of the following during pregnancy:
( ) Injections ( ) Bleeding ( ) Rashes ( ) Fever
( ) High Blood Pressure

Patient History:

Any hospitalizations or surgeries? ( ) Yes ( ) No
If yes, date, name of hospital and reason:

_____

_____

Any serious injuries? ( ) Yes ( ) No
If yes, date and injury:

_____

_____

Nutrition:

How is your child's appetite?
( ) Good ( ) Fair ( ) Poor

How is/was your infant fed? To what age?
( ) Breast ( ) Bottle ____ Months ____ Yrs.

Which of the following foods are included in child's Daily diet?
( ) Skim Milk ( ) 2% Milk ( ) Vegetables ( ) Whole Milk
( ) Meats ( ) Juices ( ) Fruits ( ) Vitamins

Family History:

Marital Status: M / S / D
Mother's age: _____
Health: ( ) Excellent ( ) Good ( ) Poor

Father's age: _____
Health: ( ) Excellent ( ) Good ( ) Poor

Number of child's siblings: _____
Step siblings ( ) Yes ( ) No If yes, how many _____
Any serious medical problems? ( ) Yes ( ) No
If yes, explain: _____

_____

Allergies:

Is your child allergic to any foods, medicines, chemicals, plants, other? ( ) Yes ( ) No

If yes, give name: _____

Reaction: _____

_____

Family Illnesses:

Check if a family member has had any of the following

( ) Allergies ( ) Anemia ( ) Epilepsy (seizures)
( ) Diabetes ( ) Asthma ( ) Stroke
( ) Cancer ( ) Sickle Cell ( ) Heart Disease
( ) Mental Disease ( ) High Blood Pressure

Other, (please specify): _____

_____

Lead Exposure:

	YES	NO	DON'T KNOW
Do you live in a house built over 30 years ago?	_____	_____	_____
Have you done any home remodeling or paint stripping?	_____	_____	_____
Do you use imported lead-glazed pottery or ceramic ware?	_____	_____	_____
Do you live near a battery plant or an industrial plant that burns solid waste products?	_____	_____	_____
Do you or your spouse work in an environment where lead-based substances are used or stored (i.e.) plumber, auto mechanic, printer, lead melter, steel welder, construction worker, gas station attendant, battery manufacturing, bridge construction?	_____	_____	_____
Does your child play near roads, freeways or in a place where she/he would breathe auto exhaust fumes or come in contact with contaminated dirt?	_____	_____	_____
Does your child eat any nonedible substances such as dirt, wood, clay, plaster, or paint chips?	_____	_____	_____

Please complete other side

Review of Systems:

Check if your child has had the following: ( ) Strep Throat ( ) Asthma ( ) Pneumonia ( ) Seizures
( ) *Eye Problems/Vision ( ) Frequent Colds ( ) Heart Murmur ( ) Frequent Ear Infections
( ) Diabetes ( ) Eczema/Skin Rash ( ) Trauma ( ) *Hearing Problem

Please list any other medical problems: _____

_____

Please list any medications that your child takes on a regular basis: _____

_____

List any physicians (other than primary care) you have seen:

_____

Development and Behavior:

At what age did your child sit alone? _____
At what age did your child walk alone? _____
Did he/she say two words by the time he/she was 24 months old? ( ) Yes ( ) No
Did he/she pedal a tricycle/big wheel by age 3 years? ( ) Yes ( ) No
Did he/she count to ten and name two colors by age 4 years? ( ) Yes ( ) No
Did he/she skip and do broad jumps by age 5 years? ( ) Yes ( ) No
Trouble sleeping? ( ) Yes ( ) No
Grade in School: _____
Trouble in School/Learning Disability? ( ) Yes ( ) No
Is patient sexually active? ( ) Yes ( ) No

Check if your child has had any of the following:
( ) Nail Biting ( ) Nightmares ( ) Bad Temper ( ) Hyperactivity ( ) Problems with Discipline
( ) Problems with Toilet Training ( ) Substance Abuse ( ) Cigarette Smoking ( ) Alcohol Use
( ) Speech Problem ( ) Bed Wetting ( ) Thumb Sucking ( ) Bottle after 18 months ( ) Pacifier after 2 years

Safety/Environment:

Is their a working smoke alarm on each floor of the child's home/apartment? ( ) Yes ( ) No
Does your child always use a car seat/seat belt when riding in the car? ( ) Yes ( ) No
Are there any cigarette smokers in the household? ( ) Yes ( ) No
Does your child always wear a helmet when riding his/her bicycle? ( ) Yes ( ) No

Is there anything else about this child you would like to discuss with the doctor? _____

_____

Signed: _____ Date: _____
(Name/Relationship to Patient)

Reviewed by: _____ Date: _____