

PEDIATRIC PATIENT HISTORY

Patient Name _____ Date of Birth _____ Date _____

Completed by _____ Relationship to patient _____

Please circle y for yes or n for no, explain where required. N/A = not applicable

Previous medical care - DR. _____ Hospital of Birth _____

Pregnancy & Birth Mother's age at pregnancy? _____
During pregnancy did mother:
y n experience illness _____
y n use medication _____
y n smoke _____
y n use alcohol _____
y n use street drugs _____
y n test positive for Hepatitis B _____
y n test positive for Syphilis _____
y n test positive for Group B Strep _____
y n test positive for HIV _____
At birth was/did baby:
y n born prematurely _____
y n delivered by Cesarean Section _____
y n jaundiced _____
y n have breathing problems _____
y n other complications _____
Birth Weight _____

Family Profile Parents: married - divorced - separated - single
Father's age? _____ Highest school grade? _____
Mother's age? _____ Highest school grade? _____
List child's brothers & sisters & their ages:

Primary Language _____

Family Medical History List all blood relatives of your child who have had the following problems - use abbreviations (F) Father, (M) Mother, (B) Brother, (S) Sister, (MGM) Mother's Mother, (MGF) Mother's Father, (PGM) Father's Mother, (PGF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia / Sickle Cell _____ Epilepsy / Seizures _____
Asthma _____ Heart Disease _____
Mental Retardation _____ High Blood Press. _____
Drug Problem _____
Alcoholism _____ High Cholesterol _____
Cancer _____ Diabetes (sugar) _____
HIV / AIDS _____
Cystic Fibrosis _____ Migraine _____
Muscular Dystrophy _____ Sudden Infant Death _____
Tuberculosis _____ Birth Defects _____
Arthritis _____ Early Deafness _____
Thyroid Disease _____ Kidney Disease _____
Other _____

Past Medical History

Has/does your child:
y n have allergy to medicine _____
y n have other allergy _____
y n take medication _____
y n had surgery (age & procedure) _____
y n been hospitalized (age & reason) _____

y n had serious Injuries (age & description) _____

Has your child had:
y n Anemia y n Heart Murmur
y n Asthma/wheezing y n Hepatitis
y n Bleeding tendency y n Hearing problem
y n Blood transfusion y n Seizures
y n Chicken pox year _____ y n Throat infections
y n Chronic ear infections y n Urinary Tract Infection
y n Eczema/Hives y n Vision problem
y n Fainting/Loss of conscious. y n Weight problem
y n Other Explain) _____

Development & Behavior

Did /Does your child:
y n sit alone by 9 months y n have behavior problems
y n walk by 15 months y n have sleep problems
y n use sentences by 3 yrs of age y n bedwet
y n participate in hobbies, sports, y n smoke
social activities y n use alcohol
y n use street drugs
Menstruation began (age) _____ last period _____
problems _____

Any Other Problems Not Mentioned Above

Feeding & Nutrition

Does/Did your child:
y n have colic or feeding problems
y n breast feed-number of months _____
y n formula feed-type _____
y n appetite usually good
y n take vitamins with Fluoride
y n have food allergies or special diet needs _____

θ Daniel P. Kraft, MD
θ Timothy C. Bell, MD
θ Shannon J. Fox-Levine, MD
θ Cheryl E. Wayne, MD
θ Nicole Pearson, MD
θ Stacey Stout, MD
θ J. Christie Goodwin, MD
θ Dionne Skervin, MD
θ Virginia Lilienthal, MD
θ M. Jayne Brennan, ARNP
θ Ann Lewis, ARNP
θ Deborah R. Nuessly, ARNP
θ Andrea Stark, ARNP
θ Jennifer Riddle, ARNP
θ Laurie Black, ARNP
θ Blair Heath, ARNP

Palm Beach Pediatrics, PA

θ 3933 N. Haverhill Rd • Suite 116 • West Palm Beach, FL 33417 • (561) 471-1144

θ 12955 Palms West Drive • Suite 100 • Loxahatchee, FL 33470 • (561) 798-2468

θ 8200 South Jog Rd • Suite 101 • Boynton Beach, FL 33472 • (561) 509-5009