PEDIATRIC HISTORY

Please complete the following information as completely as you can. This information will be helpful in gaining a better understanding of your child.

Sex: Male_____ Female_____ Handedness: Right_____ Left_____

Child's Name: _____ Age: _____ Date of Birth: _____

_____ _____
Street Address and Apt # if any City, State and Zip

Email Address: _____

Grade: _____ School: _____

Phone: Home _____ Mother _____ Father _____

Mother's Name: _____ Age: _____Education: _____

Occupation: _____ Employer: _____

Father's Name: _____ Age: _____Education: _____

Occupation: _____ Employer: _____

Marital Status: Married-When? _____ Separated-When? _____Divorced-When? _____
Widowed-When? _____ Never been married. _____

Was your child adopted (check one) Yes _____ No _____

Child's Brothers and Sisters:

Name	Age	Medical, Educational or Emotional Problems

Who referred this child? _____

Briefly describe why you are bringing your child, what problems your child has, and what questions you would like answered?

_____

_____

_____

_____

PREGNANCY AND DELIVERY

Please check any of the following that the child's mother had during her pregnancy with this child,then explain:

_____ Fever
_____ Bleeding
_____ Morning Nausea
_____ Diabetes
_____ German Measles
_____ Kidney Infection
_____ Use of alcohol/drugs/cigarettes
_____ Hospitalizations/Surgeries
_____ Took Medications (What kind? When?) _____

_____ High Blood Pressure
_____ X-rays
_____ Anemia
_____ Poor Nutrition
_____ Toxemia
_____ Emotional Problems
_____ Syphilis

Explain: _____

_____

Where was this child born? _____

Was your child born: Early (if so, how early?) _____ On Time_____ Late _____

How long was the labor? _____ Was labor induced? Yes_____ No_____

Delivery: Head first:_____ Breech _____ C-Section _____ Forceps used? Yes ____ No ____

Delivery complications? (explain) _____

Child's birth weight: _____ Apgar Scores: 1 minute _____ 5 minutes _____

At birth, was your child considered Normal _____ Abnormal _____

Check any of the following which the child had during the first week of life:

_____ Difficulty breathing
_____ Needed oxygen
_____ Blueness (cyanosis)
_____ Incubator used
_____ Feeding problems
_____ Excess vomiting
_____ Fever

_____ Seizures (convulsions
_____ Diarrhea
_____ Birth defects
_____ Jaundice
_____ Bilirubin lights used
_____ Drugs/medications
_____ Other complications

Explain any above: _____

_____

_____

When was your child taken home? _____

DEVELOPMENTAL HISTORY

Describe your child during the first year of life:

_____ Active	_____ Sickly	_____ Easy
_____ Passive	_____ Hard to please	_____ Slow to develop
_____ Content	_____ Sleeping problems	_____ Difficult
_____ Calm	_____ Happy	_____ Cuddly
_____ Cried a lot	_____ Liked to be held	_____ Rocked self
_____ Recurrent ear infections	_____ Breathing problems	_____ Would not make eye contact

Give approximate ages:

_____ Rolled over	_____ "Coo", "gurgle"
_____ Sat unsupported	_____ Said "mama", "papa"
_____ Crawled, crept	_____ Spoke first words
_____ Stood unassisted	_____ Talked in 2-3 word sentences
_____ Walked alone	_____ Toilet trained (Difficult_____ Easy_____)

Your child's physical abilities compared to other children his/her age:

Below Average _____ Average _____ Above Average _____

Has your child ever had physical/occupational therapy? _____ When? _____

Where? _____

Your child's speech/language abilities compared to other children his/her age:

Below Average _____ Average _____ Above Average _____

Have there been any concerns about his/her development? _____

_____

_____

MEDICAL HISTORY

Please indicate if your child has had any of the following and explain when, how treated, and course below:

_____ Measles	_____ Mumps	_____ Chicken pox
_____ Pneumonia	_____ High fevers	_____ Head injuries
_____ Frequent stomachaches	_____ Ulcers	_____ Diabetes
_____ Allergies	_____ Asthma	_____ Meningitis
_____ Frequent headaches	_____ Strabismus	_____ Paralysis
_____ Frequent ear infections	_____ Poisoning	Motor tics
_____ Vision problems	_____ Hearing problems	
_____ Frequent colds	_____ Frequent sore throats	

Explain (When, Treatment, Course): _____

_____

_____

MEDICAL HISTORY (continued)

Other medical problems:

Diagnosis	Date	Treatment

Hospitalizations:

Reason	Date	Treatment

Medication (Past and Present):

Name	Dosage	Reason	Date

Has your child received chemotherapy? No_____ Yes_____ If yes, when? _____

Has your child received radiation therapy? No_____ Yes_____ If yes, when? _____

Last physical exam: _____ Results: _____

Last vision exam: _____ Results: _____

Does your child wear corrective lenses? No_____ Yes_____

Last hearing exam: _____ Results: _____

Child's Pediatrician: _____

ACADEMIC HISTORY:

Did your child attend preschool or other early childhood program? No _____ Yes_____

Problems? (explain): _____

List schools child has attended in order:

School	What Grade	Grades

Has your child ever been retained? No_____ Yes_____ If yes, which grade? _____

Learning Problems? No_____ Yes_____ If yes, when? _____

Behavior Problems? No_____ Yes_____ If yes, when? _____

Social Problems? No_____ Yes_____ If yes, when? _____

Has your child ever had psychological or academic testing? No_____ Yes_____

If yes, by whom, when, and what were the results? _____

Has your child ever received special education services? No_____ Yes_____
If yes,

Type of Class	Classification	Grade