

PEDIATRIC HISTORY

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(addressograph stamp)

Date Completed _____ Date of Birth _____

Note: Please complete all items, marking "no" or "none" for each section or item if it does NOT apply to you.

ILLNESS AND INJURIES

Have you ever had:		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	German measles
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Poison ingestion
<input type="checkbox"/>	<input type="checkbox"/>	Broken bone(s)
<input type="checkbox"/>	<input type="checkbox"/>	Knocked unconscious
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infection
<input type="checkbox"/>	<input type="checkbox"/>	Ear infection(s)
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	<input type="checkbox"/>	Feeding problems
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems
<input type="checkbox"/>	<input type="checkbox"/>	Vision problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur

DRUG ALLERGIES OR REACTIONS NONE

Drug	Date of Reaction	What happened?

DRUGS CURRENTLY TAKEN NONE

(Once/month or more)

Drug	How Often	What for?

PREVENTION

Yes	No	
		Child in car seat or seat belt at all times when riding in car
		Poisons kept in a lock place
		Pools, lakes, streams properly fenced or supervised
		Knives and guns properly stored
		Fireplace screened
		Nutritious diet (your opinion)
		Brush teeth daily

HOSPITAL, SURGERY, OTHER MAJOR ILLNESS OR INJURY

Date	Describe why hospitalized, nature of surgery, what illness

TUBERCULOSIS SKIN TEST

Never had one
Negative test (year _____, _____)
Positive test (year _____, _____)

IMMUNIZATIONS

(Give dates of all in past on date/box)

DPT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus booster	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MMR	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hib	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Varicella	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Prevnar	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PEDIATRIC HISTORY

(Page 2)

(addressograph stamp)

Date Completed _____

MATERNAL HISTORY

Mother's age when this child born _____

Number of pregnancies prior to this child _____

Medical problems during this pregnancy:

(Illnesses, infections, anemia, blood pressure, etc.)

Medications taken during pregnancy: (list all):

Prenatal care was provided by: _____

Number of days mother in hospital after birth: _____

BIRTH HISTORY

Where born _____

Who delivered baby _____

Weight _____ Apgar scores (if known):
1 min _____ 5 min _____

Was baby born within 2 wks of expected day?

Yes No Early Late

Hours of labor _____

Labor was Spontaneous
 Induced

Was medication given during labor? Yes No

Delivery was: Spontaneous vaginal delivery
 Forceps
 Cesarean section

Baby position: Head first

Feet/bottom first

Problems or complications of delivery:

NEWBORN HISTORY (First few days of life)

Baby cried or breathed spontaneously within 1 or 2 min?

Yes No

Was baby jaundiced (yellow)?

Yes No

How many days in hospital? _____

Baby's problems or complications:

Was child breast fed?

Yes How long? _____ No

DEVELOPMENTAL HISTORY

Give age at which child accomplished the following skills

(Leave blank if not done currently) (Age in months)

Roll stomach to back _____

Laugh out loud _____

Reach out for objects _____

Sit without support _____

Feed self crackers _____

Say dada, mama in reference to
right person _____

Drink from a cup _____

Walk well _____

Toilet trained (daytime) _____

Combine 2 words _____

(Age in years)

Give first and last name _____

Dress self _____

SOCIAL HISTORY

Give your brief assessment in 2-3 words of **your child's** :

Personality

Ways of comforting self

Expression of anger/frustration

Cooperation/obedience

Fears

Self-satisfaction/degree of happiness

Reaction to change

Relationship to other children

Number of close friends

School performance

Child's opinion of school

What do you like best about this child?

What concerns you most about this child?

Westfield Pediatrics, P.A.

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Westfield Pediatrics, P.A.'s Notice of Privacy Practices.

Patient's Name Date of Birth Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Westfield Pediatrics, P.A. may disclose certain of my healthy information to a family member, close personal friend or other caregiver because such person is involved with my healthy care or payment relating to my health care. In that case, Westfield Pediatrics, P.A. will ***disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.***

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Westfield Pediatrics, P.A. making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Signature of Patient/Parent/Guardian

Date