ADVANCED PEDIATRICS
INITIAL PEDIATRIC HISTORY FORM

Child's Name: _____ **Birthday:** _____ **Today's date** _____

A. Birth History

1. Birthplace _____
2. Was pregnancy normal? _____
3. Was delivery normal? _____
4. Was baby full term? _____
5. Birth weight _____ length _____
6. Any nursery problems? _____

B. Growth and Development

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   Talked _____ Toilet trained _____
2. School history:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problems? _____
   _____
   Ever seen by a psychologist, speech therapist or special teachers? _____

C. Past Medical History

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail biting? _____
   Nightmares? _____
2. Diet:
   Nursed or bottle fed? _____
   Any colic problems? _____
   Used special diets? _____
3. Contagious diseases (what age?)
   Chicken pox _____
   Scarlet fever _____
   Any other? _____
4. Was your child ever diagnosed with any of the following? (what age?)
   Seizures _____ Asthma _____
   Bronchitis _____ Pneumonia _____
   Ear infections _____
   Any other? _____
5. Medications: Does your child take any medications now?
   _____
   _____

D. Hospitalizations

(When, where, why?) _____
_____
_____

E. Surgery

(When, where, why?) _____
_____

F. Serious Injuries

(When, where?) _____
_____
_____

G. Allergic Reactions

(Drugs, immunizations, asthma, hives, eczema, etc.) _____
_____

H. Family History

1. Father: Living _____ Age: _____ Health: _____
2. Mother: Living _____ Age: _____ Health: _____
3. Brother/Sisters: _____ How many? _____
   Ages _____ Healthy? _____
4. Any family history of:
   Diabetes _____ Allergies _____ Convulsions _____
   Heart disease _____ TB _____ Cancer _____
   Other? _____

I. General Information

Has your child had any unusual problems with the following?
Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones/Muscles/Joints _____
Skin _____
Blood _____

J. Immunizations

Did you bring a record of immunizations of your Child?
_____ Yes _____ No

K. Any special comments about your child?

_____
_____
_____
_____
_____