Carolina Pediatric Group
Patient History Form

Date_____

Child's Name _____ DOB_____ Age_____ Male___ Female___
Mother's Maiden Name_____

Date of Last WELL EXAM: _____

Family History
Please list all people living in child's home:

Name / Age / Relationship to child / Health Problems
_____
_____
_____
_____
_____

Are child's parents ___married ___unmarried
___separated ___divorced

Father's occupation_____
Mother's occupation_____
Childcare situation (who and hours per day)_____
_____
_____

Please circle any illnesses that run in <u>mother</u> and <u>father</u>'s families: allergies anemia asthma diabetes seizures or epilepsy deafness birth defects bleeding disorder drug/alcohol abuse heart disease (before age 50) high cholesterol kidney disease migraine headaches high blood pressure SIDS

Pregnancy and Birth
Mother's age at birth _____ Did mother take any medications? If yes, what?_____
Was delivery difficult? _____ Vaginal or C-section? If C-section, why? _____
How many weeks gestation? _____ Birth weight _____
Did mother have any illnesses during pregnancy? (If yes, what) _____
List any problems during newborn hospital stay?_____
Was your child breastfed? _____ If yes, how long? _____

Medical History
Do you consider your child to be in good health? If not, why?_____
Does your child take any regular medications?_____ If yes, what are they? _____
Allergic reactions to foods, medications, insects, other? If yes, give name and reaction
_____
Has your child been hospitalized or had surgery? If yes, why and when _____
_____
Any serious reactions to immunizations? If yes, which ones? _____
Please circle any illnesses <u>your child</u> has or has ever had: allergies asthma frequent ear infections anemia eczema frequent strep throat difficulty hearing vision problems heart problems or murmur urinary tract infections diabetes bleeding problems constipation seizures frequent headaches growth problems Other_____

Development
At what age did your child: sit alone_____ walk alone _____ toilet train _____
Did your child have any words by 18 months? If so, about how many? _____
Do you have concerns about attention span or activity level? _____
Has your child failed or repeated a grade in school? _____
Has your child required tutoring outside of the classroom or placement in a special or resource class? _____

Safety/Environment
Do you live in a _____private home _____apartment _____mobile home
Is there a working smoke alarm on each floor of the house? _____
Does your child always use a car seat/belt? _____
Does your child always wear a helmet when skating or bicycling? _____
Any concerns about lead exposure? (old home/peeling paint) _____
Is the child exposed to smokers? _____ If so, who? _____
Any pets in the home? _____ If yes, what kind? _____
Any guns in the home? _____ If yes, are they securely locked? _____
What is your primary drinking water? ____Well _____City _____Bottled