

PEDIATRIC PLACE

PATIENT HEALTH HISTORY

Name _____ Date of Birth _____

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|---|-----|-----|
| 1. Did you have any serious illness/hospitalization during your pregnancy? | No | Yes |
| 2. Was your child delivered more than 3 weeks early? | No | Yes |
| 3. Was the birth weight less than 4 lbs. 14 oz. or more than 9 lbs.? | No | Yes |
| 4. Did your baby receive oxygen or medicines? | No | Yes |
| 5. Does your child have any allergies to food/antibiotics/medications?
If Yes, Please List | No | Yes |
| 6. Does your child have digestion problems? | No | Yes |
| 7. Does your child have a balanced diet? | Yes | No |
| 8. Have any children in the family died? | No | Yes |
| 9. Was your child delayed in walking, talking, or becoming toilet trained? | No | Yes |
| 10. Are you happy with the adult and child relationships in your family? | Yes | No |
| 11. Is discipline a problem? | No | Yes |
| 12. Are your child's immunizations up to date? | Yes | No |
| 13. Does your child attend special classes? | No | Yes |
| 14. Are there any school problems? | No | Yes |

FAMILY HISTORY: Mother's health problems _____

Father's health problems _____

Circle any family illness and indicate which of the child's relatives have the illness noted.

M=Mother F=Father GP=Grandparent S=Sibling C=Cousin U=Uncle A=Aunt

Cystic Fibrosis _____	Sickle Cell _____
Tuberculosis _____	Cancer _____
Seizures _____	High Blood Pressure _____
Diabetes _____	Birth Defects _____
Asthma _____	Kidney Disease _____
Retardation _____	Bone/Joint Disease _____
Learning Disorders _____	Thyroid Disease _____
Physical Handicaps _____	Spastic Colon/Irritable Bowel _____
Other illnesses that run in the family _____	

INFECTIONS AND ILLNESS – Please list medications your child takes regularly. _____

Please circle any of the following that your child has had:

Heart Problems	Pneumonia	Kidney/Bladder Infection
Hives	Dental Problems	More than 3 ear infections
Unusual Thirst	Convulsions	More than 3 strep throats
Hay Fever	Wheezing/Asthma	Frequent/persistent headaches
Surgery	Hospitalization	Frequent/painful urination
Anemia	Broken Bones	Marked change in weight

Are there any special concerns you have about your child or your family? _____

Authorization for medical treatment: I authorize David E Samara, MD, PA; Jennifer Darrow, MD, PA; Malini Hebbur, MD, PA; William Stanton, MD, PA; Chioma Okammor, MD, PA; Loyette Stewart, RN, CPNP; Michele Hickman, RN, CPNP; or Kathleen Speer, PhD, RN, CPNP to treat (Child's Name) _____ as considered necessary in my absence.

Date: _____ Signature: _____