

## PEDIATRIC HISTORY

Date \_\_\_\_\_ Referred By \_\_\_\_\_

Patient Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Names of Parents/Guardians \_\_\_\_\_

Purpose for Contacting Us? \_\_\_\_\_

Other doctors seen for this condition \_\_\_\_\_

Treatment \_\_\_\_\_

**Check any of the following that pertains to your child:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD            | <input type="checkbox"/> Temper Tantrums     |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Auto Accident   | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Seizures           | <input type="checkbox"/> A Fall          | <input type="checkbox"/> Chronic Colds       |
| <input type="checkbox"/> Colic          | <input type="checkbox"/> Recurring Fevers   | <input type="checkbox"/> Traumatic Birth | <input type="checkbox"/> Adverse Vaccination |
| <input type="checkbox"/> Scoliosis      | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Reaction            |

\_\_\_\_ Other \_\_\_\_\_

Family History \_\_\_\_\_

Name of Pediatrician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Reason \_\_\_\_\_ Treatment \_\_\_\_\_

**Number of Doses of antibiotics your child has taken:**

- 1) In the last 6 months: \_\_\_\_\_
- 2) Total during his/her life: \_\_\_\_\_

**Number of doses of other prescription medications your child has taken:**

- 1) During the last 6 months: \_\_\_\_\_
- 2) Total during his/her life: \_\_\_\_\_

Vaccination History: (List Vaccines and When Given) \_\_\_\_\_

**Feeding History:**

☐ Breast-fed If yes, how long? \_\_\_\_\_ ☐ Formula If yes, how long? \_\_\_\_\_

Introduced solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months.

## PEDIATRIC HISTORY

### **Prenatal History:**

☐ Complications during pregnancy? Explain \_\_\_\_\_

☐ Ultrasounds during pregnancy? How many? \_\_\_\_\_

☐ Medications during pregnancy/delivery? List them \_\_\_\_\_

\_\_\_\_ Cigarette/alcohol use during pregnancy? Frequency \_\_\_\_\_

**Location of Birth** ☐ Hospital ☐ Home ☐ Other \_\_\_\_\_

**Birth Intervention** ☐ Forceps ☐ Vacuum Extraction ☐ C-Section

**Delivery Complications?** \_\_\_\_ No \_\_\_\_ Yes

If Yes - Explain \_\_\_\_\_

**Birth Weight** \_\_\_\_\_ **Birth Length** \_\_\_\_\_ **APGAR Scores** \_\_\_\_\_

### **Childhood Diseases:**

☐ Chicken Pox Age: \_\_\_\_ ☐ Rubella Age: \_\_\_\_ ☐ Whooping Cough Age: \_\_\_\_

☐ Rubeola Age: \_\_\_\_ ☐ Mumps Age: \_\_\_\_ ☐ Other \_\_\_\_\_

### **Developmental History:**

**At what age was your child able to:**

Respond to sound \_\_\_\_\_ Crawl \_\_\_\_\_ Sit \_\_\_\_\_ Stand Alone \_\_\_\_\_

Respond to visual stimuli \_\_\_\_\_ Hold head up \_\_\_\_\_ Walk Alone \_\_\_\_\_

**Has your child ever been involved in a car accident?** ☐ No ☐ Yes

If Yes - Explain \_\_\_\_\_

**Has your child ever fallen?** ☐ No ☐ Yes

If Yes - Explain \_\_\_\_\_

**Prior Surgery?** ☐ No ☐ Yes

If Yes - Explain \_\_\_\_\_

**I hereby authorize Advanced Health and Wellness Center, Inc. to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment in full at this time.**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_