

The Childrens' Clinic

Patient History

Last Name _____ First Name _____ Date of Birth _____

Other Children, Age, & Sex _____

Were there problems with the

Pregnancy? NO _____ YES _____ Describe _____

Labor? NO _____ YES _____ Describe _____

Delivery? NO _____ YES _____ Describe _____

Birth Weight _____

Did your newborn have breathing problems? NO _____ YES _____ Describe _____

Did your baby stay in the hospital longer than one week? NO _____ YES _____ How Long? _____

Did you breast feed your baby? NO _____ YES _____ How Long? _____

When were solids introduced? _____

Have there been problems with growth and development? NO _____ YES _____

Describe _____

When did your child sit on own? _____ months

When did your child walk on own? _____ months

Does your child have a speech problem? NO _____ YES _____

Describe _____

Has your child ever repeated a grade in school? NO _____ YES _____

Describe _____

Has your child missed any immunizations? NO _____ YES _____

Describe _____

Has your child had any of the following? Please give date and description.

accidents _____
broken bones _____
head injuries _____
operations _____
x-rays _____
blood transfusions _____

Does your child have any allergies? NO _____ YES _____ Describe _____

Is there a family history of allergies? NO _____ YES _____ Describe _____

List the medications and vitamins your child takes.

Name	Dosage
_____	_____
_____	_____
_____	_____

Does your child go to daycare? _____ NO _____ YES

List hospital admissions.

Date	Hospital	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

What doctors have cared for your child?

Doctor's Name	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had:

	YES	NO		YES	NO
recurrent colds	_____	_____	stomach flu	_____	_____
ear infections	_____	_____	tonsillitis (strep throat)	_____	_____
sinusitis	_____	_____	German measles	_____	_____
bronchitis	_____	_____	chicken pox	_____	_____
asthma	_____	_____	mumps	_____	_____
pneumonia	_____	_____	jaundice	_____	_____
croup	_____	_____	eczema	_____	_____

Has your child had a problem with:

	YES	NO		YES	NO
headaches	_____	_____	vomiting	_____	_____
double vision	_____	_____	diarrhea	_____	_____
blurred vision	_____	_____	tummy pain	_____	_____
loss of vision	_____	_____	constipation	_____	_____
poor hearing	_____	_____	back pain	_____	_____
earache	_____	_____	fainting	_____	_____
pus in eyes	_____	_____	limp	_____	_____
nosebleeds	_____	_____	seizure	_____	_____
hay fever	_____	_____	arthritis	_____	_____
chest pain	_____	_____	rash	_____	_____
shortness of breath	_____	_____	hives	_____	_____
wheezing	_____	_____		_____	_____
chronic cough	_____	_____		_____	_____
coughing up blood	_____	_____		_____	_____
blueness in lips	_____	_____		_____	_____
tiring easy	_____	_____		_____	_____

