

# The Childrens' Clinic

## Patient History

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Other Children, Age, & Sex \_\_\_\_\_

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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	_____	_____		_____	_____

