# PEDIATRIC PATIENT HISTORY

**Patient's Name** _____ **Sex** M/F **Date of Birth** _____**Age** _____

Parents' Names _____ & _____

Address _____ City_____ State_____ Zip_____

Home Telephone_____

Dad Work_____ Dad Cell_____

Mom Work_____ Mom Cell_____

**Is this a Wellness Visit or is there a Concern?** **Wellness_____ Concern_____**

**About the Chief Complaint / Concern:**

Problem _____ Onset _____

Cause, if known _____ Previous Treatment _____

Other problems you wish to discuss _____

**During the pregnancy with this child, was there any:**

Trauma Motor Vehicle Accident_____ Falls _____ Other Trauma _____

Morning Sickness Y/N Onset at week_____ Ended at week_____ Treatment_____

Indigestion Y/N Onset at week_____ Ended at week_____ Treatment_____

Prescription Medication Used Medication_____ Condition_____

Over the Counter Medication Used Medication_____ Condition_____

Other Problem(s)_____

**About the Delivery:**

Baby was born at ____ weeks Labor_____ hours Hospital _____ Midwife_____ Home birth_____

Vaginal Delivery _____ Cesarean Section _____ Was the Birth Induced? _____ Anesthesia _____

Were Forceps used? _____ Vacuum Extraction? _____

Occipital Presentation_____ Frank Breech_____ Footling_____ Face Presentation_____

Other Complications_____

**Baby's Condition Immediately After Birth:**

Apgar Scores _____/_____

Crying Baby cried immediately after birth_____ Did Not Cry for _____ minutes

Cried Strongly_____ Weak Cry_____ Did Not Cry_____

Baby's Color at Birth Pink all over_____ Blue Face_____ Blue Hands/Feet_____

Baby Needed Intensive Care_____ Days in Neonatal Intensive Care Unit_____ Baby home on day_____

Birth Weight _____lbs/kgs Birth Length _____ins/cms

**Baby's Condition the First Month of Life:**

Slept Well _____ Slept Poorly _____ Difficult Feeding ____ Cried a Lot_____

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Do you have Health Insurance? Y/N If YES, please provide insurance card to be photocopied.
I will be paying today by Cash_____ Check_____ Charge_____ Other Arrangement_____
I understand and agree that health/accident policies are an arrangement between an insurance carrier and myself; all services rendered are charged directly to me and that I am personally responsible for payment.

Parent/Guardian's Signature_____ Date_____