

# Pediatric Case History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
First MI Last

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_ Siblings: \_\_\_\_\_

Why are you seeking care for your child today? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_ Please Describe: \_\_\_\_\_

## ALL CHILDREN

Pediatrician's Name: \_\_\_\_\_ Date of Last Visit to MD: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Child's Current Medication: \_\_\_\_\_

Has your child ever been treated on an emergency basis? ☐ Yes ☐ No Please explain: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Injuries: \_\_\_\_\_

Has your child been immunized? ☐ Yes ☐ No

Has your child been involved in a motor vehicle accident? ☐ Yes ☐ No

Are they up to date? ☐ Yes ☐ No

Explain: \_\_\_\_\_

Check any of the following conditions your child has or has had:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Neck Pain        |
| <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Digestive Disorders    | <input type="checkbox"/> Paralysis        |
| <input type="checkbox"/> Arm Pain                | <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Pleurisy         |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Pneumonia        |
| <input type="checkbox"/> Backaches               | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Polio            |
| <input type="checkbox"/> Bed Wetting             | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Poor Appetite    |
| <input type="checkbox"/> Behavioral Problems     | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Broken Bones            | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Scoliosis        |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Heart Problems/Defects | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> Chronic Ear Infections  | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Chronic Colds           | <input type="checkbox"/> Hyperactivity          | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Cold Sores              | <input type="checkbox"/> Leg Pain               | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Congenital Birth Defect | <input type="checkbox"/> Measles                | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Mononucleosis          | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Other: _____     |

## FOR INFANTS ONLY:

Birth Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Type of Birth: check all that apply Normal Vaginal Forceps Breech Cesarean Home Birth Midwife MD

Problems during pregnancy:

Problems during labor/delivery:

Congenital Anomalies/ Birth Defects:

Infant Feeding: Breast Milk Formula Type(s): \_\_\_\_\_

Solid Food What age began: \_\_\_\_\_ -

Hours of sleep per night: \_\_\_\_\_ Quality of Sleep: Good Fair Poor

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AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER TESTS AND TREATMENTS AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.

\*\*Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

