



# PEDIATRIC PERSONAL HISTORY

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  
School Grade \_\_\_\_\_ Family's Religious Preference \_\_\_\_\_  
Ethnicity \_\_\_\_\_

## **Prenatal History:**

Mother's health during this pregnancy:

Infections \_\_\_\_\_ Other \_\_\_\_\_  
Toxemia \_\_\_\_\_

Number of previous pregnancies \_\_\_\_\_ Number live births \_\_\_\_\_

X-rays during pregnancy \_\_\_\_\_

Medications taken during pregnancy \_\_\_\_\_

## **Birth History:**

Duration of pregnancy \_\_\_\_\_ Duration of labor \_\_\_\_\_

Type of delivery? Cesarean/Spontaneous vaginal/Forceps assisted

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_

## **Neonatal History:**

Apgar scores: birth \_\_\_\_\_ 5 minutes \_\_\_\_\_

Respiratory distress at birth? \_\_\_\_\_ Were resuscitative efforts required? \_\_\_\_\_

Did your baby have problems with:

\_\_\_ Jaundice \_\_\_ Fevers  
\_\_\_ Anemia \_\_\_ Seizures

## **Feeding History:**

Was child breast fed? \_\_\_\_\_ If so, how long? \_\_\_\_\_

How well did your baby take the first feeding? \_\_\_\_\_

If your infant bottle-fed:

Type of formula? \_\_\_\_\_

Has your child had problems with vomiting? \_\_\_\_\_

Has your child had problems with colic? \_\_\_\_\_

Has your child had problems with diarrhea? \_\_\_\_\_

Age of your child when solid foods introduced? \_\_\_\_\_

Supplementation with vitamins/fluoride? \_\_\_\_\_

Problems with formula or food intolerance? \_\_\_\_\_

How did you manage this problem? \_\_\_\_\_

## **Developmental History:**

How old was your child when first able to sit unassisted? \_\_\_\_\_

How old was your child when first able to roll from back to stomach? \_\_\_\_\_

How old was your child when able to stand alone? \_\_\_\_\_

How old was your child when first able to take three steps alone? \_\_\_\_\_

**Past Medical History:**

- |   |   |
|---|---|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Lung Disease             |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Back Problems      | <input type="checkbox"/> Major Injuries/Illnesses |
| <input type="checkbox"/> Bleeding Problems  | _____   |
| <input type="checkbox"/> Blood Transfusions | _____   |

**Current Medications** -including Vitamins and Herbals:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Allergies:**

**Please circle**

- |                   |     |    |
|-------------------|-----|----|
| Tetanus antitoxin | yes | no |
| Penicillin        | yes | no |
| Sulfa             | yes | no |
| Other Drugs       | yes | no |

PLEASE LIST \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |           |     |    |
|-----------|-----|----|
| Foods     | yes | no |
| Eggs      | yes | no |
| Cosmetics | yes | no |
| Other     | yes | no |

PLEASE LIST \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgeries:**

- |                                      |                                      |                                       |
|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Abdomen     | <input type="checkbox"/> Head        | <input type="checkbox"/> Thyroid      |
| <input type="checkbox"/> Appendix    | <input type="checkbox"/> Heart       | <input type="checkbox"/> Tonsils      |
| <input type="checkbox"/> Back        | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Uterus/Ovary |
| <input type="checkbox"/> Breast      | <input type="checkbox"/> Hernia      | <input type="checkbox"/> Any Biopsies |
| <input type="checkbox"/> Eyes        | <input type="checkbox"/> Prostate    | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Skin        | _____                                 |

**Social History:**

- Child lives with (mother \_\_\_\_\_)(father \_\_\_\_\_)(both \_\_\_\_\_)(other \_\_\_\_\_)
- Number of siblings? \_\_\_\_\_ Their ages? \_\_\_\_\_
- Does child ever use alcohol? \_\_\_\_\_ tobacco? \_\_\_\_\_ illicit drugs? \_\_\_\_\_
- Has your child ever been pregnant? \_\_\_\_\_
- How much time per day does your child watch television? \_\_\_\_\_
- Is your child involved in sports, hobbies or church activities? Or play a musical instrument? \_\_\_\_\_
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