

PERSONALCARE PEDIATRICS
 PATIENT & FAMILY HISTORY-

OP _____

| CHILD'S NAME: | |
|---|-----------------------|
| DOES YOUR CHILD HAVE ALLERGIES TO: | IF YES EXPLAIN |
| Medications | |
| Animals | |
| Foods | |
| Inside Allergens | |
| | |
| DOES YOUR CHILD HAVE ANY OF THE FOLLOWING: | IF YES EXPLAIN |
| Serious injuries or accidents | |
| Surgeries | |
| Hospitalizations | |
| Any specialist seen | |
| (AI) Allergic rhinitis or other allergy | |
| (AI) Asthma, bronchitis, bronchiolitis, pneumonia or croup | |
| (AI) Animal allergy | |
| (AI) Indoor allergy | |
| (AI) Outdoor allergy | |
| (CV) Heart problems or heart murmur | |
| (DERM) Chronic or recurrent skin problems "Acne, eczema, etc." | |
| (ENDO) Diabetes | |
| (ENDO) Thyroid or other endocrine problems | |
| (ENT) Frequent ear infections or sinus infections | |
| (ENT) Pharyngitis/tonsillitis | |
| (ENT) Problems with ears or hearing | |
| (EYE) Conditions/Corrective Lenses | |
| (GI) Constipation requiring doctor visits | |
| (GI) Abdominal pain/GER | |
| (GU) Bed-wetting (after 5 years of age) | |
| (GU) Bladder or kidney infection or other Urologic problem | |
| (GYN) If female, any problems with periods? | |
| (GYN) If female, have menstrual periods started? | |
| (HEME) Anemia or bleeding problem | |
| (HEME) Blood transfusion | |
| (ID) Chickenpox | |
| (ID) Other infectious illnesses | |
| (NEURO) Frequent headaches | |
| (NEURO) Seizures, developmental delays, ADD/ADHD or other neurological disorder | |
| (ORTHO) Orthopedic problems | |
| (PSY) Emotional problems | |
| (PSY) Mental health concerns | |
| (PSY) Use of alcohol or drugs | |
| (Z) Other significant problems | |
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| Do these diseases run in your family? | Give person affected- only go as far back as child's grandparent...please specify maternal or paternal grandparent |
|---|--|
| Nasal allergies or other allergies | |
| Asthma/lung disease | |
| Heart disease or heart condition | |
| High blood pressure | |
| High cholesterol | |
| Diabetes or endocrine problem | |
| Cancer | |
| Anemia | |
| Bleeding problems | |
| Epilepsy or convulsions | |
| Mental retardation or developmental disorders | |
| Neurological disorder including ADD/ADHD | |
| Liver disease | |
| Other GI disease or disorder | |
| Kidney disease | |
| Bed-wetting (After the age of 10) | |
| Hearing impairment | |
| Vision impairment or eye disorder | |
| Immune problems, recurrent infections, other/AIDS | |
| Alcohol abuse | |
| Drug abuse | |
| Mental illness | |
| Tuberculosis | |
| Other Pertinent Conditions | |
| | |
| SOCIAL HISTORY | GIVE DETAILS |
| Who lives with your child-list all relationships/friends etc... in home | |
| Does non-custodian parent have full access to child's health care? | |
| Siblings | |
| Pets | |
| Does anyone smoke in the child's home | |
| | |
| BIRTH HISTORY | GIVE DETAILS |
| Where was your child born? | |
| Full term or Preterm | |
| Did he or she stay in the NICU? | |
| If yes, WHY? | |
| Was your child treated for jaundice? | |
| How much did your child weigh at birth? | |

