Lifetime Family Health Center

PEDIATRIC HISTORY FORM

PATIENT NAME:_____NICKNAME:_____DATE:_____

ADDRESS: _____CITY: _____ STATE: ____ ZIP: _____

SSN: _____ BIRTHDAY: _____ AGE:_____ ☐ MALE ☐ FEMALE

NAME OF PARENTS/GUARDIANS: _____

HOME PHONE:_____CELL PHONE:_____

HOW DID YOU FIRST HEAR OF LIFETIME FAMILY HEALTH CENTER?

☐ PARENT IS A PATIENT ☐ TV ☐ NEWSPAPER ☐ BILLBOARD ☐ FRIEND ☐ OTHER: _____

PURPOSE FOR CONTACTING US? _____

OTHER DOCTORS SEEN FOR THIS CONDITION? ☐ YES ☐ NO IF YES, PLEASE LIST DOCTORS AND TREATMENTS:

1. _____

2. _____

3. _____

REGARDING CONDITION:

IS IT RELATED TO AN AUTOMOBILE ACCIDENT? ☐ NO ☐ YES

HOW DID THIS HAPPEN?_____

WHEN DID THE SYMPTOMS FIRST START? _____

HOW FREQUENT ARE THE SYMPTOMS?_____

DESCRIBE THE SYMPTOMS: _____

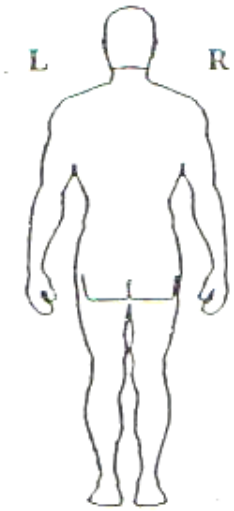
WHAT MAKES IT WORSE?_____

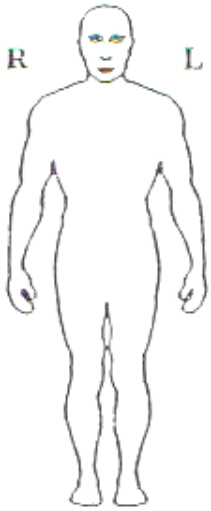
WHAT MAKES IT BETTER? _____

DOES IT RADIATE TO ANY OTHER PARTS OF THE BODY?_____

HAS THIS CHANGED ACTIVITIES AT HOME? _____

Please mark all the areas of complaint on the diagrams below.





PRENATAL HISTORY:

MOM'S HEALTH DURING PREGNANCY: _____

COMPLICATIONS DURING PREGNANCY: ☐ NO ☐ YES ; PLEASE LIST: _____

MEDICATIONS DURING DELIVERY: INDUCTION ☐ YES ☐ NO EPIDURAL ☐ YES ☐ NO OTHER: _____

BIRTH INTERVENTION: ☐ FORCEPS ☐ VACUUM EXTRACTION ☐ CAESARIAN – EMERGENCY / PLANNED?

COMPLICATIONS DURING DELIVERY: ☐ NO ☐ YES ; PLEASE LIST: _____

DELIVERY: ☐ < 36 WEEKS ☐ 37 – 42 WEEKS ☐ > 42 WEEKS

BIRTH WEIGHT: _____ LENGTH _____

FEEDING HISTORY:

BREAST FED: ☐ YES ☐ NO HOW LONG? _____

FORMULA FED: ☐ YES ☐ NO HOW LONG? _____

INTRODUCED TO SOLIDS AT: _____MONTHS; COW'S MILK AT _____ MONTHS

FOOD/JUICE ALLERGIES OR INTOLERANCES ☐NO ☐YES; PLEASE LIST: _____

HEALTH HISTORY:

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM DURING THE LAST 6 MONTHS:

☐ EAR INFECTIONS	☐ SEIZURES	☐ NECK PAIN
☐ ASTHMA/ALLERGIES	☐ ADHD/ADD	☐ BACK PAIN
☐ COLIC	☐ CHRONIC COLDS	☐ SLEEPLESSNESS
☐ SCOLIOSIS	☐ RECURRING FEVERS	☐ CAR ACCIDENT
☐ DIGESTIVE PROBLEMS	☐ HEADACHES	☐ OTHER: _____
☐ BED WETTING	☐ GROWING PAINS	

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐YES ☐ NO IF YES, WHY? _____

HAS YOUR CHILD HAD ANY SIGNIFICANT INJURIES?_____

IS YOUR CHILD ON ANY MEDICATIONS? _____

HAS YOUR CHILD TAKEN ANY ANTIBIOTICS? ☐ NO ☐ YES;

IF YES, HOW MANY DOSES IN THE LAST 6 MO? _____ TOTAL DURING HIS/HER LIFETIME: _____

HAS YOUR CHILD BEEN VACCINATED? ☐ NO ☐ YES WHEN: _____

ANY CHILDHOOD DISEASES?

☐ CHICKEN POX	☐ WHOOPING COUGH	☐ RSV
☐ RUBELLA	☐ MUMPS	☐ OTHER: _____
☐ MEASLES	☐ PERTUSSES	

DOES YOU CHILD TAKE A MULTIVITAMIN OR ANY OTHER NUTRITIONAL SUPPLEMENTS? _____

HOW MANY SERVINGS OF FRUITS AND VEGETABLES DOES YOU CHILD EAT ON A DAILY BASIS:_____

HOW MANY SODAS (12OZ) DOES YOUR CHILD DRINK PER DAY? _____ HOW MUCH WATER (IN OZ) PER DAY? _____

WHAT POSITION DOES YOUR CHILD SLEEP IN? BACK SIDE STOMACH HOW MANY PILLOWS DOES HE/SHE USE?_____

DAILY ACTIVITES/SPORTS

IS YOUR CHILD INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC) _____

PLEASE LIST ANY INJURIES AS A RESULT OF THEIR ACTIVITIES: _____

_____

PARENT/GUARDIAN SIGNATURE:_____DATE: _____