

**HUGUENOT PEDIATRICS  
PATIENT HISTORY**

Please list all drug allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**MATERNAL & BIRTH HISTORY**

Length of pregnancy \_\_\_\_\_ Birth Weight \_\_\_\_\_ Complications with pregnancy or delivery \_\_\_\_\_

Problems at birth: (Circle all that apply) Breathing difficulty, jaundice, infection, other \_\_\_\_\_

Type of feeding: Breast/Bottle \_\_\_\_\_

**PAST MEDICAL HISTORY**

Hospitalizations (Date & Reason) \_\_\_\_\_

Surgery (Date & Reason) \_\_\_\_\_

Recurrent or Chronic Illness \_\_\_\_\_

**ILLNESSES**

Has your child had problems with: (Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Vision                   | <input type="checkbox"/> Heart Murmur                  | <input type="checkbox"/> Broken Bones          |
| <input type="checkbox"/> Hearing                  | <input type="checkbox"/> Dental problems               | <input type="checkbox"/> Serious Injury        |
| <input type="checkbox"/> Frequent Colds           | <input type="checkbox"/> Feeding problems              | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> 3 or more ear infections | <input type="checkbox"/> Any Food intolerance          | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Repeated Strep Throat    | <input type="checkbox"/> Problems with bowel movements | <input type="checkbox"/> Hives                 |
| <input type="checkbox"/> Recurrent Croup          | <input type="checkbox"/> Problems with urination       | <input type="checkbox"/> Eczema                |
| <input type="checkbox"/> Asthma or wheezing       | <input type="checkbox"/> Bed wetting                   | <input type="checkbox"/> Chickenpox            |
| <input type="checkbox"/> other                    |  |  |

**FAMILY HISTORY**

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Health Problems \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Health Problems \_\_\_\_\_

Children's Names: 1. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Health Probs. \_\_\_\_\_  
2. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Health Probs. \_\_\_\_\_  
3. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Health Probs. \_\_\_\_\_  
4. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Health Probs. \_\_\_\_\_

Family medical problems: Check all that apply and indicate relationship to patient

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Psychiatric         |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug/Alcohol         | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Early Heart Disease  | <input type="checkbox"/> Sudden Infant Death |
| <input type="checkbox"/> Bleeding  | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Suicide             |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Deafness  | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Other               |

**DEVELOPMENTAL HISTORY**

Has your child had problems with: (Circle all that apply): Toilet training, Behavior, Speech, School, Developmental, Milestones (walking, talking, self-help skills on time)