

PEDIATRIC INFORMATION FORM

NAME: _____

DATE: _____

Please list specific health concerns you have for your child, in order of importance:

- 1.
- 2.
- 3.

Do you have any specific goals for your child's health?

- a)
- b)
- c)

What is your child's disposition?

ALLERGIES (medications, food, environmental):

Your child's health history (Please check):

NOW	PAST	NOW	PAST
_____	_____ Acne	_____	_____ Epilepsy/Seizures
_____	_____ Allergies	_____	_____ Fatigue
_____	_____ Anemia	_____	_____ Frequent Infections
_____	_____ Asthma	_____	_____ Headaches
_____	_____ Bed Wetting	_____	_____ Heart Murmur
_____	_____ Birth Defects	_____	_____ High Fever
_____	_____ Colic	_____	_____ Hyperactivity
_____	_____ Constipation	_____	_____ Insomnia
_____	_____ Cough/Wheeze	_____	_____ Jaundice
_____	_____ Cradle Cap	_____	_____ Learning Disorder
_____	_____ Depression	_____	_____ Moodiness
_____	_____ Diarrhea	_____	_____ Stuffy Nose
_____	_____ Dizzy Spells	_____	_____ Thrush
_____	_____ Earaches	_____	_____ Vomiting Spells
_____	_____ Eczema	_____	_____ Other:

MEDICATIONS:

NOW	PAST
_____	_____ Aspirin
_____	_____ Tylenol
_____	_____ Antibiotics
_____	_____ Decongestants
_____	_____ Other

List currently used PRESCRIPTION MEDICINES with dosages:

Med: _____ Dosage: _____ Times/Day: _____

Med: _____ Dosage: _____ Times/Day: _____

Med: _____ Dosage: _____ Times/Day: _____

List currently used SUPPLEMENTS (Vitamins, minerals, herbs): with dosages:

Sup: _____ Dosage: _____ Times/Day: _____

Sup: _____ Dosage: _____ Times/Day: _____

Sup: _____ Dosage: _____ Times/Day: _____

CHILDHOOD ILLNESSES:

_____ Chicken Pox	_____ Scarlet Fever	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Ear Infections
_____ Mumps	_____ Rubella	_____ Strep Throat
_____ Tonsillitis	_____ Pneumonia	_____ Croup
_____ Whooping Cough	_____ Asthma	_____ Other:

SURGERIES/HOSPITALIZATIONS (include ear tubes, tonsillectomy):

Surgery: _____ Date: _____ Outcome: _____

Surgery: _____ Date: _____ Outcome: _____

Surgery: _____ Date: _____ Outcome: _____

IMMUNIZATIONS (List types, dates given, and any adverse reactions):

Does your child always use helmets when biking, skiing, or skating, and use seat belts with age appropriate booster seats? Yes/No (please circle)

SOCIAL HISTORY:

Parents: Married _____ Separated _____ Divorced _____

Mother's Occupation _____ Full time _____ Part time _____

Father's Occupation _____ Full time _____ Part time _____

Guardian _____ Relationship _____

Others Residing in Home _____ Relationship _____

Daycare _____ Where _____

Siblings: Name: _____ Age: _____ Health History: _____

- 1) _____
- 2) _____
- 3) _____
- 4) _____

PRENATAL/BIRTH/FEEDING HISTORY:

Mother's Health During the pregnancy with this child:

Please check and describe in the space provided.

Age:	Trauma/Injury:	Alcohol Consumption:
Bleeding:	Stress:	Drugs:
Nausea:	High Blood Pressure:	Smoking:
Illness:	X-Rays:	Toxemia:
Medications:	Other:	

Term: Full _____ Premature _____ Late _____ Birth Weight _____

Was Pregnancy/Birth: Easy? _____ Difficult? _____

Place of Birth: Hospital _____ Home _____ Clinic _____ Other _____

Feeding:

Breast Fed _____ How Long _____

Formula _____ How Long _____

Age Solid Foods Began _____ What Foods _____

Food Intolerances _____

Favorite Foods _____

List a typical diet of your child:

Breakfasts:

Lunches:

Dinners:

Snacks:

Fluids:

Average Sleep Per Night (*actual* amount, not *ideal* amount):

Number of Hours Per Night _____ Continuous/Interrupted (please circle one)

Additional Comments: