# The Childrens' Clinic

## Patient History

Last Name ____________________ First Name ________________ Date of Birth __________

Other Children, Age, & Sex ______________________________________________________

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Were there problems with the

Pregnancy? NO_____ YES _____ Describe______________________________________

Labor? NO_____ YES _____ Describe______________________________________

Delivery? NO_____ YES _____ Describe______________________________________

Birth Weight______________________________

Did your newborn have breathing problems? NO_____ YES _____ Describe_______________

Did your baby stay in the hospital longer than one week? NO_____ YES _____ How Long?____

Did you breast feed your baby? NO_____ YES _____ How Long?___________

When were solids introduced? _________________________________________________

Have there been problems with growth and development? NO_____ YES _____

Describe ____________________________________________________________________

When did your child sit on own? _____________months

When did your child walk on own? ___________months

Does your child have a speech problem? NO_____ YES _____

Describe____________________________________________________________________

Has your child ever repeated a grade in school? NO_____ YES _____

Describe____________________________________________________________________

Has your child missed any immunizations? NO_____ YES _____

Describe____________________________________________________________________

## Has your child had any of the following? Please give date and description.

accidents________________________________________________________________

broken bones_____________________________________________________________

head injuries____________________________________________________________

operations_______________________________________________________________

x-rays___________________________________________________________________

blood transfusions_______________________________________________________

Does your child have any allergies? NO_____ YES _____ Describe______________________

Is there a family history of allergies? NO_____ YES _____ Describe______________________

## List the medications and vitamins your child takes.

| Name | Dosage |
|---|---|
| | |
| | |
| | |

Does your child go to daycare? _____NO _____YES

## List hospital admissions.

| Date | Hospital | Reason |
|---|---|---|
| | | |
| | | |
| | | |

## What doctors have cared for your child?

| Doctor’s Name | Date | Reason |
|---|---|---|
| | | |
| | | |
| | | |

## Has your child had:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| recurrent colds | ______ | ______ | stomach flu | ______ | ________ |
| ear infections | ______ | ______ | tonsillitis (strep throat) | ______ | ________ |
| sinusitis | ______ | ______ | German measles | ______ | ________ |
| bronchitis | ______ | ______ | chicken pox | ______ | ________ |
| asthma | ______ | ______ | mumps | ______ | ________ |
| pneumonia | ______ | ______ | jaundice | ______ | ________ |
| croup | ______ | ______ | eczyma | ______ | ________ |

## Has your child had a problem with:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| headaches | ______ | ______ | vomiting | _______ | ________ |
| double vision | ______ | ______ | diarrhea | _______ | ________ |
| blurred vision | ______ | ______ | tummy pain | _______ | ________ |
| loss of vision | ______ | ______ | constipation | _______ | ________ |
| poor hearing | ______ | ______ | back pain | _______ | ________ |
| earache | ______ | ______ | fainting | _______ | ________ |
| pus in eyes | ______ | ______ | limp | _______ | ________ |
| nosebleeds | ______ | ______ | seizure | _______ | ________ |
| hay fever | ______ | ______ | arthritis | _______ | ________ |
| chest pain | ______ | ______ | rash | _______ | ________ |
| shortness of breath | ______ | ______ | hives | _______ | ________ |
| wheezing | ______ | ______ | | _______ | ________ |
| chronic cough | ______ | ______ | | _______ | ________ |
| coughing up blood | ______ | ______ | | _______ | ________ |
| blueness in lips | ______ | ______ | | _______ | ________ |
| tiring easy | ______ | ______ | | _______ | ________ |

## Has anyone in your family had:

| | YES | NO |
|---|---|---|
| kidney problems | ___________ | ___________ |
| high blood pressure | ___________ | ___________ |
| bleeding problems | ___________ | ___________ |
| congenital problems (problems from birth) | ___________ | ___________ |
| seizures | ___________ | ___________ |
| heart disease | ___________ | ___________ |
| children who died (give cause) | ___________ | ___________ |

## Other problems

**Thank you for filling out this form.**