DELTA PEDIATRICS

INITIAL PEDIATRIC HEALTH HISTORY

Your child's health is important to us. Please fill out this form as completely and as accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss with you. All information is treated confidentially.

PATIENT INFORMATION

Patient Name: _____,_____,_____ ☐ Male ☐ Female
Last First Middle

Date of Birth: _____-_____-_____ Age:_____ Child's Prior Pediatrician:_____
Month Day Year
Preferred Method of Contact (Choose one) ☐ Phone ☐ Email ☐ Mail

Are there any pets in the home? ☐ No ☐ Yes _____
Can we send lab results to your email? ☐ No ☐ Yes
Does anyone smoke in the home? ☐ No ☐ Yes

GENERAL INFORMATION

Reason for today's visit? _____

Does your child have any serious illness or medical condition? ☐ yes ☐ no Explain:_____
Has your child had any serious accidents? ☐ yes ☐ no Explain:_____
Has your child had any surgery? ☐ yes ☐ no Explain:_____
Has you child ever been hospitalized? ☐ yes ☐ no Explain:_____
Is your child allergic to any medicines or drugs? ☐ yes ☐ no Explain:_____
Is your child currently taking any medications (either prescription or non-prescription)? ☐ yes ☐ no Explain:_____

CHILD'S BIRTH HISTORY

Birth weight: ____ lbs ____ oz.	Did mother have any complications with her pregnancy? ☐ No ☐ Yes, Explain
Child born ☐ Term ☐ Early ☐ Late? If early how many weeks gestation?	Was the delivery ☐ vaginal ☐ cesarean If cesarean, why? _____

MEDICAL HISTORY

Check box ONLY if your child has or has ever had any of the following:

- ☐ Abdominal pain (frequent)
- ☐ Alcohol or drug use
- ☐ Allergies
- ☐ Anemia or a bleeding problem
- ☐ Asthma, bronchitis, bronchiolitis, or pneumonia
- ☐ Bed-wetting (after age 5)
- ☐ Blood transfusion
- ☐ Breathing difficulties
- ☐ Broken bones or sprains
- ☐ Chickenpox
- ☐ Constipation
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Earache
- ☐ Ear infections
- ☐ Ear or hearing problem
- ☐ Epilepsy or convulsions
- ☐ Eye or vision problems
- ☐ Headaches (frequent)
- ☐ Heart problem or murmur
- ☐ Hepatitis
- ☐ Measles, rubella, mumps
- ☐ Menstrual periods started (for girls)
- ☐ Menstrual period problems (for girls)
- ☐ Nausea / vomiting
- ☐ Nosebleeds
- ☐ Rectal Bleeding
- ☐ Rheumatic fever
- ☐ RSV
- ☐ Sinus problems
- ☐ Skin conditions (chronic) – i.e. eczema
- ☐ Sore throat, strep throat
- ☐ Stomachache (frequent)
- ☐ Thyroid or endocrine problem
- ☐ Urinary tract infection

☐ Any other significant problem _____

Guarantor Signature:_____ Date:_____