Springhurst pediatrics

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Name _____ DOB _____
Date _____

I Present Illness/Medications – (See medication list) _____

_____

Allergic to:

(Age 3 and under: All Sections) (Age over three: Sections D-G)

II Past Medical History

A. Mothers Prenatal Care
Complications _____
Exposure to X-rays _____
Medications _____
_____
_____

Circle those that apply:
Drugs/Alcohol/Tobacco _____
Cesarean/Forceps/Complicated Labor/Delivery
Explain _____

B. Newborn History
Birth weight _____
Premature or Full Term _____
Complications _____
Hospital of Birth _____

C. Nutrition
Breast/Bottle _____
Feedings/oz. per day _____
Solids _____

D. Injuries/Poisoning _____
_____
_____

E. Hospitalizations/Surgeries: (tubes, hernia, Tonsils, etc.)
AGE DIAGNOSIS
_____
_____

F. Developmental
Smiled at _____
Crawled _____
Sentences _____
Sat Alone _____
Walked Alone _____
Any concerns about development _____
_____
Performance at School _____
_____
Behavioral Difficulties _____
_____

G. Childhood Diseases
Chickenpox _____
Measles/Mumps _____
Strep/Rheumatic fever _____
Other _____

III. Social History
Who lives in home; Parents, siblings, grandparents? _____
Who cares for child when parent not there?
_____
Alcohol/Drugs used by family members?
_____
Exposure to Violence (self, family, other)?
_____
Is there a gun in the home? _____
Car Seats/Smoke Alarms/poison control? _____
Where does child sleep? _____

IV Family History (Section III – All Patients) (parents, grandparents, brothers, sisters)

	YES	NO
Vision Problems	☐	☐
Hearing Problems	☐	☐
Birth Defects	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
Blood Disorders	☐	☐
Mental Disorders	☐	☐
High Blood Pressure	☐	☐
Sudden Infant Death	☐	☐
Asthma/COPD/Emphysema	☐	☐
Diabetes/ Thyroid Disorder	☐	☐
Allergies/Immune Disorder	☐	☐
Neurological Disorder/Seizures	☐	☐
Kidney Disease	☐	☐
Bone/Muscle/Joint Disorder	☐	☐
Attention Deficit Disorder/ Hyperactivity	☐	☐
Cancer	☐	☐
Alcoholism/Drug Use	☐	☐

V. Review of Systems(Section IV – All Patients)

A. EENT	YES	NO
Frequent Colds	☐	☐
Sore Throats	☐	☐
Ear Infections	☐	☐
Nose Bleeds	☐	☐
Hearing Problems	☐	☐
Visual Problems	☐	☐
Speech Problems	☐	☐
Tubes in Ears	☐	☐

B. Cardiorespiratory		
Heart Murmur	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Positive TB Test	☐	☐
BCG	☐	☐
Smokers in Home	☐	☐

C. Gastrointestinal		
Vomiting/Reflux	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Stools in underwear	☐	☐
Feeding Difficulties	☐	☐
Abdominal Pain	☐	☐
Blood in Stool	☐	☐

D. Genitourinary		
Wets the Bed	☐	☐
Pain on Urination	☐	☐
Urinates more Frequently than usual	☐	☐
Toilet trained at what age _____		
Blood in urine	☐	☐
Boys – good urine stream	☐	☐

E. Reproductive		
Had Sex Education	☐	☐
Knows Birth Control	☐	☐
Sexually Active	☐	☐
Vaginal Discharge	☐	☐
Age at First Period _____		
Periods Normal	☐	☐

F. Neurological		
Headaches	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Hyperactivity	☐	☐
Weakness	☐	☐

G. Musculoskeletal		
Joint Swelling	☐	☐
Joint Pain	☐	☐
Bone Pain	☐	☐
Broken Bones	☐	☐

H. Hematological		
Anemia/Takes Iron	☐	☐
Abnormal Bleeding/Bruising	☐	☐
History of Transfusions	☐	☐
Sickle Cell Anemia/Trait	☐	☐

I. Allergy		
Tested for Allergies	☐	☐
Hives	☐	☐
Allergy Shots	☐	☐
Reactions to:		
Medicine	☐	☐
Bee Stings	☐	☐
Food	☐	☐
Other	☐	☐

Comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date _____ Providers Signature _____