DOVETAIL Family Practice
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PEDIATRIC HISTORY

Parent:
This is a health questionnaire on your child. **Please complete this form.**

DATE: _____
Child's Name: _____D.O.B. _____
Mother's Name: _____
Father/ Partner: _____

This child lives with: (list all individuals that live in the home)

NAME	RELATIONSHIP TO CHILD

BIRTH HISTORY:
1. Where was baby born:

_____
2. Was labor induced: **NO YES**
3. Was labor helped by medication: **NO YES**
4. Duration of labor: _____
5. Was baby born early: (less than 38 weeks) **NO YES**
6. Was baby born late (after 42 weeks) **NO YES**
7. What was the method of delivery:
Spontaneous vaginal
Forceps
Breech
Caesarean Reason: _____
8. Birth weight of baby: _____ Length: _____ H/C: _____

9. Apgar score, if known:_____
10. During hospital stay, did baby have any of the following:
a. Jaundice **NO YES**
b. Antibiotic treatment **NO YES**
c. Rash **NO YES**
d. Blue spells **NO YES**
e. Convulsions **NO YES**
f. Did baby remain in hospital longer than mother? **NO YES**
11. How was baby fed?
Breast
Bottle

PRENATAL HISTORY:
1. While pregnant, did mother have:
a. High blood pressure **NO YES**
b. Bleeding or spotting **NO YES**
c. Kidney Disease **NO YES**
d. Toxemia **NO YES**
e. Gestational diabetes **NO YES**
f. Threatened Miscarriage **NO YES**
g. German Measles (Rubella) **NO YES**
h. Illness other than cold or flu **NO YES**
i. Premature labor **NO YES**
2. Were medications or herbs taken during pregnancy? **NO YES**
If yes, what kind:
_____
3. Was a fertility treatment used for this pregnancy? **NO YES**
If yes, what kind:
_____

DEVELOPMENTAL HISTORY:
1. At what age did child:
a. Hold up head _____
b. Roll over _____
c. Sit unsupported _____
d. Stand alone _____
e. Walk _____
f. Talk _____
g. Toilet train _____
h. Feed her/himself _____
i. Dress her/himself _____

IMMUNIZATIONS:
PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES

PAST MEDICAL HISTORY:
1. Has the child had:
a. Chicken pox **NO YES**
b. Measles (Rubeola) **NO YES**
c. German Measles (Rubella) **NO YES**
d. Mumps **NO YES**
e. Meningitis **NO YES**
f. Convulsions **NO YES**
g. Contusions **NO YES**
h. Fractures **NO YES**
i. Poison Ingestion **NO YES**
j. Operations **NO YES**
k. Blood transfusions **NO YES**
l. Blood: anemia (iron deficiency, Sickle Cell, Thalassemia) **NO YES**
m. Hospitalizations **NO YES**
If yes, what illness? _____
n. Other serious medical illnesses: **NO YES**
If yes, what kind? _____
o. Is your child currently taking any medications, vitamins, or herbs: **NO YES**
(if yes please list medication name, dose and how often it is administered):

p. Reaction to drug or foods (allergy) **NO YES**
If yes, please
explain:_____
q. Any chronic or recurring pain? **NO YES**
If yes, please
explain:_____
2. Eyes:
a. Any visual problems? **NO YES**
b. Do eyes look crossed? **NO YES**
c. Does the child wear glasses? **NO YES**
3. Ears:
a. Any hearing problems? **NO YES**
b. Three or more ear infections? **NO YES**

4. Nose:
a. Does the child have frequent attacks of sneezing or rubbing his/her nose? **NO YES**
b. Has the child had frequent nose bleeds? **NO YES**
5. Throat:
a. Does your child have three or more strep throat infections per year? **NO YES**
6. Heart: Have you ever been told your child has:
a. A heart murmur **NO YES**
b. High blood pressure **NO YES**
c. Heart defect **NO YES**
7. Lungs: Has your child ever had:
a. Bronchitis or pneumonia **NO YES**
b. Asthma/wheezing **NO YES**
c. Chronic cough **NO YES**
8. Does your child tire easily? NO YES
9. Abdomen: Has your child ever had:
a. Jaundice **NO YES**
b. Blood in bowel movement **NO YES**
c. Frequent abdominal pain **NO YES**
d. Frequent vomiting or diarrhea **NO YES**
e. Marked weight loss **NO YES**
f. Difficulty with appetite or eating? **NO YES**
If yes, please
explain:_____
10. Kidney:
a. Has your child ever had a urinary tract infection? **NO YES**
b. Has there ever been blood in the urine? **NO YES**
c. Does your child ever wet the bed? **NO YES**
d. Does your child ever complain of burning or frequency of urination? **NO YES**
11. Skin:
a. Any sensitivity or allergy? **NO YES**
b. Eczema or atopic dermatitis? **NO YES**
c. Acne? **NO YES**
12. Extremities: Has your child:
a. Had weakness or paralysis of arms or legs? **NO YES**
b. A persistent limp? **NO YES**
c. Ever worn corrective shoes or braces **NO YES**
13. Neurological: Has your child ever had **NO YES**
a. Frequent headaches **NO YES**
b. Convulsions or seizures **NO YES**
c. Dizziness **NO YES**
d. Fainting **NO YES**
e. Breath holding **NO YES**

f. Temper tantrums **NO YES**

14. Is your child:

a. Overactive **NO YES**
b. Impulsive **NO YES**
c. Lacking in self control **NO YES**
d. Does your child have problems with:
- Peers **NO YES**
- Siblings **NO YES**
- Parents **NO YES**
- Sleep **NO YES**
- Attention span **NO YES**
- Attending school **NO YES**
- Learning **NO YES**
- Mood **NO YES**

e. Are there concerns about physical, sexual, or emotional abuse? **NO YES**

15. Has your child begun puberty? NO YES

Is there a history in the family of:

a. Tuberculosis **NO YES**
b. Diabetes **NO YES**
c. Asthma, hay fever, eczema, allergies **NO YES**
d. Mental Disorder **NO YES**
e. Seizures **NO YES**
f. Hepatitis **NO YES**
g. Heart disease, stroke, high cholesterol **NO YES**
h. Cancer **NO YES**
If yes, what kind: _____
i. Birth defects, genetic defects **NO YES**
j. Other serious medical problems **NO YES**

Are there any other concerns you would like to discuss? _____
_____
_____

*_____ _____
SIGNATURE OF PARENT/ GUARDIAN **DATE**

*_____ _____
PHYSICIAN SIGNATURE **DATE**