Pediatric Case History

Name: _____ Date of Birth: _____ Age: _____
First MI Last

Mother's Name: _____ Father's Name: _____ Siblings: _____

Why are you seeking care for your child today? _____

When did this problem begin? _____ Please Describe: _____

ALL CHILDREN

Pediatrician's Name: _____ Date of Last Visit to MD: _____

Reason for visit: _____

Childs Current Medication: _____

Has your child ever been treated on an emergency basis? □ Yes □ No Please explain: _____

Hospitalizations: _____ Surgeries: _____

Injuries: _____

Has your child been immunized? □ Yes □ No
_____
Are they up to date? □ Yes □ No

Has your child been involved in a motor vehicle accident? □ Yes □ No
Explain: _____

Check any of the following conditions your child has or has had:

- □ Anemia
- □ Appendicitis
- □ Arm Pain
- □ Asthma
- □ Backaches
- □ Bed Wetting
- □ Behavioral Problems
- □ Broken Bones
- □ Cancer
- □ Chicken Pox
- □ Chronic Ear Infections
- □ Chronic Colds
- □ Cold Sores
- □ Congenital Birth Defect
- □ Constipation
- □ Diabetes
- □ Diarrhea
- □ Digestive Disorders
- □ Diphtheria
- □ Dizziness
- □ Eczema
- □ Epilepsy
- □ Fainting
- □ Fetal Alcohol Syndrome
- □ Headaches
- □ Heart Problems/Defects
- □ HIV/AIDS
- □ Hyperactivity
- □ Leg Pain
- □ Measles
- □ Mononucleosis
- □ Mumps
- □ Neck Pain
- □ Paralysis
- □ Pleurisy
- □ Pneumonia
- □ Polio
- □ Poor Appetite
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Scoliosis
- □ Sinus Problems
- □ Thyroid Disorder
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Whooping Cough
- □ Other:_____

FOR INFANTS ONLY:

Birth Weight: _____ Current Weight: _____

Type of Birth: check all that apply Normal Vaginal Forceps Breech Cesarean Home Birth Midwife MD

Problems during pregnancy:

Problems during labor/delivery:

Congenital Anomalies/ Birth Defects:

Infant Feeding: Breast Milk Formula Type(s): _____

Solid Food What age began: _____-

Hours of sleep per night: _____ Quality of Sleep: Good Fair Poor

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AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER TESTS AND TREATMENTS AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.

**Guardian Signature: _____ Date: _____