Whom may we thank for referring you to this office →
_____?

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____Today's Date _____/ _____/____

M D Y
Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____

Current Height: _____ Current Weight: _____ Age: _____

Address _____

City _____Postal Code _____

Mothers name _____ Mother's phone _____

Fathers name: _____ Father's phone_____

Pediatrician/Family MD _____City _____

Last Visit: ____/____/____ Reason for visit:_____
M D Y

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

*If your child is experiencing **Pain/Discomfort please identify where and for how long_____***

_____
_____

1. **When did the** Problem first begin? Date ____/____/_____ _____Unknown
2. **Ever had** this problem **before**? No___ Yes___ If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes, *(Describe)*_____
4. Have you seen any **other doctors** for this problem? No___ Yes ___ If yes who? _____

5. How long ago? _____Days _____ Weeks _____ Months _____Years

6. What were the results of past treatment?

_____
____

7. How is this problem **NOW:** ▫ Rapidly Improving ▫ Improving Slowly ▫ About the Same ▫ Gradually Worsening ▫ On & Off

8. Please list any **medication taken** for this problem:
_____
___

9. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

_____
___

10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

_____
____

HAS YOUR CHILD EVER SUFFERED FROM: *Mark a* **Y for *YES*** *OR* ***N for NO***

□ Headaches □ Orthopedic Problems □ Digestive Disorders □ Behavioral Problems
□ Dizziness □ Neck Problems □ Poor Appetite □ ADD/ADHD

□ Fainting □ Arm Problems □ Stomach Aches □ Ruptures/Hernia
□ Seizures □ Leg Problems □ Reflux □ Muscle Pain
□ Heart Trouble □ Joint Problems □ Constipation □ Growing Pains
□ Chronic earaches □ Backaches □ Diarrhea □ Allergies to-
_____
□ Sinus Trouble □ Poor Posture □ Hypertension □ Asthma

□ Scoliosis □ Anemia □ Colds/Flu □ Walking Trouble
□ Bed Wetting □ Colic □ Broken Bones □ Sleeping Problems
□ Fall in baby walker □ Fall from bed or couch □ Fall from crib □ Fall off swing
□ Fall off bicycle □ Fall from high chair □ Fall off slide □ Fall down stairs
□ Fall from changing table □ Fall off monkey bars □ Fall off skateboard/skates

□ Other: _____