PEDIATRIC CASE HISTORY

Child's Name:_____ Mother's Name:_____
Last First Middle Last First Middle
Case Number:_____ Father's Name:_____
Last First Middle

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Father's Work Phone:_____

Birth Date:_____ Age:_____ Birth Weight:_____ Current Weight:_____

Sex:___ No. of Siblings:_____ Birth Length:_____Current Length:_____
Type of Birth:
Normal Vaginal:_____ Forceps:_____ Breech:_____ Cesarean:_____

Home:_____ Birthing Center:_____ Hospital:_____
Problems During
Pregnancy:_____
Problems During
Labor/Delivery:_____

Apgar Scores:_____ Was there presence at birth of:_____ Jaundice (Yellow)
_____ Cyanosis (Blue)
Congenital Anomalies/ Defects:_____

Infant Feeding: Breast:_____ Bottle:_____ Formula:_____

No. of hours sleep per night:____Quality of sleep: Good:_____ Fair:_____ Poor:_____

Obstetrician/ Midwife: _____
Name Address

Pediatrician/ Family MD:_____
Name Address
Date of last visit to MD:_____ Purpose:_____
Immunization History:_____
Purpose of this Appointment:_____
Has your Child ever been treated on an emergency basis?:_____
Describe:_____
Insurance/ Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/ daughter (upon approval of parent or guardian)

Signed:_____ Witnessed:_____ Date:_____
I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-Rays remain the property of this clinic.
Date:_____ Signature:_____

PEDIATRIC CASE HISTORY

Pregnancy History:_____

Delivery/ Birth History:_____

Developmental History: At what age did the child:

_____Respond to sound
_____Follow an object with his/ her eyes
_____ Hold head up
_____ Sit Alone
_____ Crawl
_____ Stand
_____ Walk Alone

Childhood Diseases:_____ Chickenpox
_____ Mumps
_____Measles
_____ Rubella
_____Rubeola
_____Whooping Cough

Has this child ever suffered from: (Circle)

Dizziness	Backaches	Heart Trouble	Chronic Earaches
Diabetes	Tuberculosis	Hypertension	Colds/ Flu
Arthritis	Headaches	Asthma	Allergies
Neuritis	Digestive disorders	Sinus Trouble	Constipation
Anemia	Rheumatic Fever	Orthopedic Problems	Diarrhea
Poor Appetite	Hyperactivity	Sugar Concentration	Behavioral Problems
Bed Wetting	Convulsions	Paralysis	Muscle Jerking
Fainting	Walking Problems	Broken Bones	Ruptures/ Hernias
Neck Problems	Arm Problems	Leg Problems	"Growing Pains"
Joint Problems	Blood Disorders	Stomach Aches	Other

Present History:_____

Surgery:_____

Accidents:_____

Family History:_____