

PURCELLVILLE PEDIATRICS PATIENT HISTORY FORM

Child's Name _____

Date of Birth _____

Gender M/F

Allergies _____

Medications _____

Immunizations _____ Up-to-Date _____ Not Up-to-Date _____ Declined

Please list any hospitalizations, surgeries, injuries, chronic, or major illnesses:

Date	Hospital/Doctor's Name	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History

Were there any problems during the mother's pregnancy? _____ Yes _____ No
 Did the baby come more than 2 weeks early or 2 weeks late? _____ Yes _____ No
 Were there any problems during labor or delivery? _____ Yes _____ No
 What was the baby's birth weight? _____
 Were there any problems during the nursery stay? _____ Yes _____ No

Family History – Do any members of the family, including grandparents, have

Allergies/Hay fever _____ Yes _____ No	Thyroid problems _____ Yes _____ No
Asthma/Wheezing _____ Yes _____ No	Diabetes _____ Yes _____ No
Early heart disease (age 50 or less) _____ Yes _____ No	Seizures/Epilepsy _____ Yes _____ No
High blood pressure _____ Yes _____ No	Kidney problems _____ Yes _____ No
Early unexpected death _____ Yes _____ No	Other _____
High cholesterol _____ Yes _____ No	

Patient General History – Has the patient had

Frequent ear infections _____ Yes _____ No	Frequent stomachaches _____ Yes _____ No
Frequent colds/sore throats _____ Yes _____ No	Chronic diarrhea/constipation _____ Yes _____ No
Seasonal allergies _____ Yes _____ No	Poor weight gain/ poor appetite _____ Yes _____ No
Croup _____ Yes _____ No	Kidney problems or infections _____ Yes _____ No
Wheezing/chronic cough _____ Yes _____ No	Anemia/ blood problems _____ Yes _____ No
Bronchitis/ Pneumonia _____ Yes _____ No	Delayed development _____ Yes _____ No
Eye problems _____ Yes _____ No	Behavior problems _____ Yes _____ No
Hearing problems _____ Yes _____ No	Learning problems/disabilities _____ Yes _____ No
Eczema/skin problems _____ Yes _____ No	Emotional disorders _____ Yes _____ No
Heart murmur / condition _____ Yes _____ No	Seizures/ convulsions _____ Yes _____ No
Frequent headaches _____ Yes _____ No	