

## PEDIATRIC CASE HISTORY

Child's Name: \_\_\_\_\_ Sex:  M  F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ #of Siblings: \_\_\_\_\_ Ages of Siblings: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Length: \_\_\_\_\_

Type of Birth:  Normal Vaginal  Forceps  Breech  Cesarean

Place of Birth:  Home  Birthing Center: \_\_\_\_\_  Hospital: \_\_\_\_\_

Obstetrician/Midwife: \_\_\_\_\_ Pediatrician/Family MD: \_\_\_\_\_

Date of Last Visit to MD: \_\_\_\_\_ Purpose: \_\_\_\_\_

Problems During Pregnancy: \_\_\_\_\_

Problems During Labor/Delivery: \_\_\_\_\_

APGAR Scores: \_\_\_\_\_ Congenital Defects: \_\_\_\_\_

Jaundice (yellow) at Birth:  Yes  No Cyanosis (blue) at Birth:  Yes  No

Infant Feeding:  Breast  Bottle  Formula

# of Hours of Sleep/Night: \_\_\_\_\_ Quality of Sleep:  Good  Fair  Poor

Immunization History: \_\_\_\_\_

Purpose of this Appointment: \_\_\_\_\_

Has your child ever been treated on an emergency basis?  Yes  No

**If Yes** please describe: \_\_\_\_\_

\_\_\_\_\_

**HAS THIS CHILD HAD ANY OF THE FOLLOWING?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Backaches        | <input type="checkbox"/> Neuritis          | <input type="checkbox"/> Convulsions              |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Bed-Wetting              |
| <input type="checkbox"/> Colds/Flu        | <input type="checkbox"/> Rubella (Measles) | <input type="checkbox"/> Walking Problems         |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Heart Trouble     | <input type="checkbox"/> Arm Problems             |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Hypertension      | <input type="checkbox"/> Blood Disorders          |
| <input type="checkbox"/> Poor Appetite    | <input type="checkbox"/> Sinus Trouble     | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Orthopedic Problems      |
| <input type="checkbox"/> "Growing Pains"  | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Digestive Disorders      |
| <input type="checkbox"/> Mumps            | <input type="checkbox"/> Muscle Jerking    | <input type="checkbox"/> Sugar Concentration      |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Neck Problems     | <input type="checkbox"/> Stomach Aches            |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Joint Problems    | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Whooping Cough    | <input type="checkbox"/> Behavioral Problems      |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Chronic Earaches  | <input type="checkbox"/> Leg Problems             |
| <input type="checkbox"/> Fainting         | <input type="checkbox"/> Broken Bones      | <input type="checkbox"/> Other _____              |

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family History: \_\_\_\_\_

**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/ward: \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_

I realize that I am responsible for all fees charged by this clinic and I agree to be responsible for all services as they are performed. X-rays remain the property of this clinic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

