

Patient Name: \_\_\_\_\_

# the Pediatric Group

Birth through 12 years

History form to be filled out  
by Parent — CONFIDENTIAL

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

My child usually gets his care at \_\_\_\_\_ . His last physical examination was \_\_\_\_\_ months or \_\_\_\_\_ years ago.

I am here for this visit only and my child receives his care elsewhere.  Yes  No

If your response to the above is Yes, there is no need to go any further with this questionnaire.

If your child is not receiving care elsewhere and you want him to receive his care here, you can help us take better care of him by answering the following questions.

If your child is over 3 years old, is he/she too sick today to have his eyes checked?  Yes  No

Is he/she too sick today or are you too rushed for us to test how he/she is developing?

(approximately 15 minutes)  Yes  No

## I. PREGNANCY AND BIRTH

Check One

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Did you have any illnesses during your pregnancy?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Did you carry him/her for a full 9 months?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Where was your baby born? _____   |                              |                             |
| 4. How much did he/she weigh at birth? _____ lb., _____ oz.                                |                              |                             |
| 5. Did your baby have any trouble starting to breathe?                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Did your baby have any trouble in the hospital, such as yellow jaundice or Blue spells? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Did your baby go home with you when you left the hospital?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. How long did he/she stay in the hospital? _____ days                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## II. FEEDING AND DIGESTION

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Did your baby have severe colic or unusual feeding problems during the first 3 months of life? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. If on vitamins, what kind and how much? _____  |                              |                             |
| 3. If you don't live in a city, are you using fluoride each day?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are you giving iron?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. If still on formula, which one do you use? _____   |                              |                             |
| 6. Is your child's appetite usually good?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do any foods bother him/her?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does he/she often have diarrhea or runny bowels?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Does your child have itching around the rectum?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## III. BABY SHOTS, TESTS AND DEVELOPMENT

Has your child had:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. A scar from a smallpox vaccination?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. His/her "DPT" baby shots? If so, how many?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. All doses of poliovaccine by mouth? If so how many?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Measles shot? At what age?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Rubella shot (German Measles)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Mumps shot?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Skin test for tuberculosis?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Was it negative?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Did your child sit alone before 7 months of age?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Did your child walk along before 15 months of age?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Did your child say any words by 1 1/2 years of age?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Is he/she as quick in learning as your other children?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Does your child speak clearly, if not what sounds are hard to understand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## IV. ALLERGIES

Has your child had:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Eczema, hives or itching that is hard to stop?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Wheezing or asthma?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Allergies or reactions to any medicines or injections such as Penicillin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has he ever had penicillin or ampicillin?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does he/she have a constant cold, hayfever, or sinus trouble?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does your child have itchy eyes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

V. FAMILY-SOCIAL HISTORY

- 1. Are both parents in good health?  Yes  No
- 2. Do any other members of your child's immediate family (brothers, sisters, parents, grandparents, aunts, uncles) have a serious health problem (mental or physical)  Yes  No
- 3. How many people live in your home? Children \_\_\_\_\_ Adults \_\_\_\_\_
- 4. With whom does the child live? (circle one) both parents mother father  
legal guardian other \_\_\_\_\_
- 5. Does anyone help you take care of your child on a regular basis?  Yes  No
- 6. Who sleeps in the room with the child? \_\_\_\_\_
- 7. Does he/she have his/her own bed?  Yes  No
- 8. Do you have well water?  Yes  No
- 9. What kind of heat? \_\_\_\_\_
- 10. Is the bathroom inside?  Yes  No
- 11. Do you have indoor plumbing?  Yes  No

VI. INFECTIONS, ILLNESS, AND OTHER PROBLEMS

Has your child:

- 1. Had more than 6 colds or throat infections each year?  Yes  No
- 2. Had more than 3 ear infections, draining ears, or earaches?  Yes  No
- 3. Had any trouble hearing?  Yes  No
- 4. Had his/her hearing tested? When \_\_\_\_\_  Yes  No
- 5. Had any trouble seeing, or wear glasses?  Yes  No
- 6. Had his/her eyes tested? When \_\_\_\_\_  Yes  No
- 7. Had nose bleeds that are hard to stop or that bleed too often?  Yes  No
- 8. Had any trouble with his/her teeth?  Yes  No
- 9. Seen a dentist recently?  Yes  No
- 10. Had any trouble passing his/her urine?  Yes  No
- 11. Had any unusual color or smell to the urine?  Yes  No
- 12. Had headaches or dizziness?  Yes  No
- 13. Been short of breath, turned blue or had a heart murmur?  Yes  No
- 14. Ever had a convulsion or fit or fainting spell?  Yes  No
- 15. Had any of the following? (circle which ones) 3-day measles 7-day measles chickenpox  
mumps whooping cough pneumonia
- 16. Had other diseases?  Yes  No
- 17. Had to stay in the hospital overnight?  Yes  No  
Age \_\_\_\_\_ Hospital \_\_\_\_\_ Why \_\_\_\_\_
- 18. Missed more than 4 days of school? For what?  Yes  No

VII. ACCIDENTS

- 1. Has your child had any serious accidents? (circle one)  Yes  No  
burns poisoning cuts needing a doctor broken bones
- 2. Does your child use seat belts in your car?  Yes  No
- 3. Do you know how to prevent infant smothering or choking?  Yes  No
- 4. Do you have firearms (loaded or unloaded) in your homes?  Yes  No
- 5. Does your child know how to swim?  Yes  No

VIII. BEHAVIOR AND DISCIPLINE

- 1. Is he/she more difficult to raise than your other children?  Yes  No
- 2. What is the most effective way of disciplining your child? (circle one) spanking  
putting to room taking privileges away other \_\_\_\_\_
- 3. Are you concerned about any of the following? (circle which ones)  Yes  No  
bad temper won't mind holds his breath jealousy sleep problems  
thumbsucking nailbiting speech problems can't toilet train very shy  
doesn't pay attention overactive slow to learn eats dirt or paint bedwetting  
poor appetite masturbation

IX. SCHOOL

- 1. Does your child attend school?  Yes  No
- 2. What school does your child attend? \_\_\_\_\_ Grade \_\_\_\_\_
- 3. Does your child get along well in school?  Yes  No
- 4. Have you met with the teacher?  Yes  No
- 5. Is the teacher worried about any problems?  Yes  No
- 6. Does your child get along well with other children?  Yes  No
- 7. What does he/she do after school? \_\_\_\_\_
- 8. What are his/her favorite subjects? \_\_\_\_\_
- 9. What hobbies does your child enjoy? \_\_\_\_\_
- 10. What kind of grades does he/she get? \_\_\_\_\_