NORTH BAY PEDIATRICS

PATIENT HISTORY

NAME: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____

PROBLEMS: (E.G. JAUNDICE, PREMATURITY)

_____

FAMILY HISTORY:

DIABETES YES ____ NO ____ COMMENTS _____

SEIZURES YES ____ NO ____ COMMENTS _____

ALLERGIES YES ____ NO ____ COMMENTS _____

HEART DISEASE YES ____ NO ____ COMMENTS _____

HIGH BLOOD PRESSURE YES ____ NO ____ COMMENTS _____

ELEVATED CHOLESTEROL YES ____ NO ____ COMMENTS _____

CANCER YES ____ NO ____ COMMENTS _____

DEVELOPMENTAL HISTORY (if applicable) At what ages did the following occur?

Sat up without help _____ Fed Self _____ Crawled _____ Bladder Control _____

Walked _____ Bowel Control _____ Spoke 1st words _____ Dressed Self _____

Used simple sentences _____ Was child breast or bottle fed? _____ Any problems? _____

HEALTH AND MEDICAL HISTORY (if applicable)

Childhood Illnesses (Fill in circle if yes—note frequency & age)

o Multiple Ear Infections _____ o Tubes in Ears _____
o Asthma _____ o Allergies (to what?) _____
o Seizures (when was last one?) _____

Please list & describe any other important injuries, illnesses, major operations or developmental problems & when they occurred:

_____

Please list medications child is currently taking and what they are being taken for:

Name of Medication & For What:

_____

Has vision been examined? _____ Results: _____ Does child wear glasses? _____ At what age were they prescribed? _____

Has hearing been tested? _____ Results: _____ Does child wear hearing aid? _____ At what age was it prescribed? _____