

# PEDIATRIC HISTORY SHEET

Name \_\_\_\_\_ DOB \_\_\_\_\_

Parents \_\_\_\_\_

Address \_\_\_\_\_

Parents' Occupation/ Employer \_\_\_\_\_ Referred by \_\_\_\_\_

## PERINATAL HISTORY

Type of delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> Forceps/Suction <input type="checkbox"/> C-Section	Apgar	1m	5m	Head circ.	<input type="checkbox"/> Breast <input type="checkbox"/> Bottle	Hospital of birth	
Complications					Birth length	Name		
Gestational age	Blood Type			M	B	Birth weight		
Other lab					Disch weight		City	
Birth abnormalities					Complications during pregnancy			State

## FAMILY HISTORY

Check if present and give relation (mother, brother etc.)

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes _____           | <input type="checkbox"/> Epilepsy _____               |
| <input type="checkbox"/> Birth defects _____      | <input type="checkbox"/> TB _____                     |
| <input type="checkbox"/> Mental retardation _____ | <input type="checkbox"/> Allergies or hay fever _____ |
| <input type="checkbox"/> Asthma _____             | <input type="checkbox"/> Other _____                  |

Name	Occupation	Age	General health		Lives in same house		Smoker		Alcohol or drug use	
			Yes	No	Yes	No	Yes	No	Yes	No
Mother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allergies \_\_\_\_\_ Major illnesses/health problems \_\_\_\_\_

Medications \_\_\_\_\_

Other \_\_\_\_\_

Medications \_\_\_\_\_ Surgeries \_\_\_\_\_

Milestones

Sat up \_\_\_\_\_ First words \_\_\_\_\_ Walked \_\_\_\_\_ Toilet trained \_\_\_\_\_

Check all that apply to child (risk assessment for lead exposure)

- |   |  |
|---|--|
| <input type="checkbox"/> Lives or frequently visits housing built prior to 1950 that is dilapidated or undergoing renovation. | <input type="checkbox"/> Lives near lead processing plant                |
| <input type="checkbox"/> Has contact with other children with known lead toxicity   | <input type="checkbox"/> Lives near busy highway or hazardous waste site |
| <input type="checkbox"/> Parent's work in lead relation occupation  |  |