LARAMIE PHYSICIANS FOR WOMEN AND CHILDREN

PEDIATRIC HEALTH HISTORY

This information becomes a part of your confidential medical record.

Date: ___________ Child's Name: ____________________________________ Date of Birth: _____________

Previous Physician: _______________________________ City/State: ______________ Phone: ____________

ALLERGIES (food or medication)

Substance Reason

____

____

____

____

CURRENT MEDICATIONS

Name Dose

____

____

____

____

MEDICAL HISTORY

Please check if the child has had any of the following:

GENERAL
- □ Anemia
- □ Asthma
- □ Birth defects
- □ Breathing problems
- □ Bronchitis
- □ Chicken Pox
- □ Headaches
- □ Hepatitis
- □ Immune deficiency
- □ Prematurity
- □ Pneumonia
- □ Sickle Cell Disease
- □ Other

CARDIOVASCULAR
- □ Heart Murmur
- □ Irregular heartbeat

EYES
- □ Crossed or wandering
- □ Eye irritation

HEARING/SPEECH
- □ Difficulty learning
- □ Ear infections
- □ Speech problems

GASTROINTESTINAL
- □ Appetite problems
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Excessive Thirst
- □ Rectal bleeding
- □ Vomiting

GENITO-URINARY
- □ Bed-wetting
- □ Blood in urine
- □ History of UTI
- □ Painful urination

MUSCLE/BONE/JOINT
- □ Broken bones or sprains
- □ Coordination problems
- □ Posture problems
- □ Pain/weakness/swelling in:
  - □ Arms □ Back
  - □ Hips □ Legs
  - □ Feet □ Neck
  - □ Hands □ Shoulders

NOSE/THROAT/CHEST
- □ Bleeding gums
- □ Difficulty breathing
- □ Difficulty swallowing
- □ Frequent colds
- □ Hoarseness
- □ Mouth breathing
- □ Nosebleeds
- □ Persistent cough
- □ Sinus problems
- □ Sore throats
- □ Tonsil infections
- □ Wheezing

SKIN
- □ Bruises easily
- □ Change in moles
- □ Eczema
- □ Hives
- □ Itching
- □ Rash

OTHER
- □ Behavior problems
- □ Depression
- □ Diabetes
- □ Dizziness
- □ Drug use
- □ Fainting
- □ Loss of sleep
- □ Mood swings
- □ Nervousness
- □ Obesity
- □ Seizures
- □ Sweating
- □ Tiredness
- □ Weight loss/gain

HOSPITALIZATIONS/SURGERIES

Date Reason

____

____

____

____

INJURIES/SEVERE ACCIDENTS

Date Type

____

____

____

____

--- OVER ---

PRENATAL HISTORY (complete if patient is under four (4) years old)

Delivery was (check all that apply):

□ Early _____(weeks) □ Normal Vaginal
□ Late □ Induced Vaginal
□ On-Time □ C-Section

Place of Birth: ____
Newborn Physician: ____________________________________
Complications at birth: _________________________________
Birth Weight:______________________________
Feeding: □ Breast □ Bottle □ Both

FAMILY HISTORY

	Age	General Health
Father	_____	_________________
Mother	_____	_________________
Sibling	_____	_________________
Sibling	_____	_________________
Sibling	_____	_________________
Other	_____	_________________

Are there any significant changes or stressors at home currently?
____
____
____

Smokers in the home? □ Yes □ No

Check if anyone in the family (parents, siblings, grandparents) had/has any of the following:

Which Relative?	Which Relative?	Which Relative?
Alcoholism	Diabetes	Lung disease
Allergies	Emphysema	Mental Illness
Asthma	Genetic defects	Muscle disorders
Arthritis	Hearing or vision problems	Seizures/convulsions
Birth defects	Heart disease	Sickle cell anemia
Blindness	Hemophilia	Skin disease
Bone/Joint disorders	HIV/AIDS	Stroke
Cancer	High blood pressure	Thyroid problems
Developmental delay	Kidney disease	Tuberculosis

For all children age 13 and older:

Has your child ever smoked or used other forms of tobacco? **Yes** **No**

If yes, does your child currently smoke or use tobacco? **Yes** **No**