HARRISONBURG PEDIATRICS, P.C.

Child's Name ______________________ Birth ____________

HISTORY TO BE FILLED OUT BY PARENT

A. PREGNANCY AND BIRTH:

1. Did you have an illness during your pregnancy? No Yes
2. Did the baby come on time? Yes No
3. What was the birth weight? ________
4. Did your baby have any trouble starting to breathe? No Yes
5. Did the baby have any trouble while in the hospital? No Yes

B. FEEDING AND DIGESTION:

1. Was there severe colic or any unusual feeding problems the first 3 months? No Yes
2. Is your child's appetite usually good? Yes No
3. Is it good now? Yes No
4. Do any foods disagree with him/her? No Yes
5. Does he/she often have diarrhea? No Yes
6. Has constipation ever been much of a problem? No Yes
7. If still on formula, what one do you use? ________

C. FAMILY HISTORY:

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters have had:

   seizures cancer inherited or family diseases
   diabetes tuberculosis asthma allergy
   nervous breakdown hypertension high cholesterol

2. Are the child's parents both in good health? Yes No
3. List ages, sex, and general health of brothers and sisters:

   ____
   ____
   ____
   ____

4. Have any of your children died? No Yes

D. INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLEMS AND DEVELOPMENT:

1. Has your child had as many as three bouts of ear trouble? No Yes
2. Does he/she usually have more than three colds or throat infections with fever a year? No Yes
3. Does he/she have any trouble with urination? no Yes
4. Has he/she ever had a convulsion? No Yes
5. Does he/she hear well? No Yes
6. Has he/she had any trouble with his/her eyes? No Yes
7. At what age did he/she sit alone? ________
8. At what age did he/she walk alone? ________
9. Did he/she say any words by the time he/she was 1½ years? Yes No
10. Does he/she have any trouble sleeping now? No Yes
11. Are there any problems with his/her teeth? No Yes
12. Circle any of the following that your child has had:

    red measles mumps chickenpox roseola
    whooping cough German measles sinusitis
    pneumonia serious accidents broken bones
    removal of tonsils and adenoids bronchitis
    insertion of ear tubes
    Other operations ________________
    Other diseases—what? ________________
    Hospitalizations-for what? ________________

13. Does he/she receive any medicines regularly now? No Yes

E. ALLERGIES:

1. Has he/she ever had eczema or hives? No Yes
2. Has he/she ever had wheezing or asthma? No Yes
3. Has he/she tend to have a stuffy nose or "constant cold?" No Yes
4. Has he/she had any allergies or reactions to any medicines or injections? No Yes

F. EMOTIONAL PROBLEMS:

1. Is he/she doing well in school? Yes No
2. Does he/she get along well with other children? Yes No
3. Underline any of the following problems

   nail biting irritable speech problems thumbsucking
   wets bed breath holding nightmares won't mind
   jealousy bad temper can't toilet train

G. TESTS AND IMMUNIZATIONS:

IF YOU HAVE YOUR CHILD'S IMMUNIZATION RECORD WITH YOU SKIP THIS SECTION.

1. Has he/she had the "DPT" or diphtheria, tetanus, and whooping cough vaccine? Yes No
2. His/her last DPT booster date:

   ____
3. Has he/she had all 3 doses of polio vaccine by mouth? Yes No
4. Has he/she had measles vaccine? Yes No

   When? ________________
5. Has he/she had a skin test for tuberculosis?

   When? ________________
6. Has he/she had the Hib vaccine Yes No

   When? ________________
7. Does he/she receive flu shots regularly? No Yes

H. Is there any other medical information you wish to share with us today. No Yes

What? ________________

I. Have you requested transfer of past medical records to our office? Yes No

ANY CHECKS IN THE RIGHT HAND COLUMN ARE INVESTIGATED

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