HUGUENOT PEDIATRICS
PATIENT HISTORY

Please list all drug allergies

_____
_____
_____

Child's Name_____ Date of Birth_____

MATERNAL & BIRTH HISTORY

Length of pregnancy_____ Birth Weight_____ Complications with pregnancy or delivery_____
Problems at birth: (Circle all that apply) Breathing difficulty, jaundice, infection, other_____
_____
Type of feeding: Breast/Bottle

PAST MEDICAL HISTORY

Hospitalizations (Date & Reason) _____
_____
Surgery (Date & Reason) _____
_____
Recurrent or Chronic Illness_____
_____

ILLNESSES

Has your child had problems with: (Check all that apply)

___Vision	___Heart Murmur	___Broken Bones
___Hearing	___Dental problems	___Serious Injury
___Frequent Colds	___Feeding problems	___Seizures
___3 or more ear infections	___Any Food intolerance	___Loss of Consciousness
___Repeated Strep Throat	___Problems with bowel movements	___Hives
___Recurrent Croup	___Problems with urination	___Eczema
___Asthma or wheezing	___Bed wetting	___Chickenpox
___other		

FAMILY HISTORY

Mother's Name_____ Age_____ Health Problems_____
Father's Name_____ Age_____ Health Problems_____
Children's Names: 1. _____ Date of Birth_____ Health Probs._____
2. _____ Date of Birth_____ Health Probs._____
3._____ Date of Birth_____ Health Probs._____
4._____ Date of Birth_____ Health Probs._____

Family medical problems: Check all that apply and indicate relationship to patient

___Anemia	___Diabetes	___Psychiatric
___Arthritis	___Drug/Alcohol	___Seizures
___Asthma	___Early Heart Disease	___Sudden Infant Death
___Bleeding	___Elevated Cholesterol	___Suicide
___Cancer	___Hypertension	___Thyroid Disease
___Deafness	___Kidney Disease	___Other

DEVELOPMENTAL HISTORY

Has your child had problems with: (Circle all that apply): Toilet training, Behavior, Speech, School, Developmental, Milestones (walking, talking, self-help skills on time)