PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME:_______________________________ MOTHER'S NAME:_________________________________

FATHER'S NAME: _________________________________

ADDRESS: ___________________________________ CITY:___________________ STATE: _____ ZIP: ________

HOME PHONE: __________________ MOTHER'S CELL: _________________ FATHER'S CELL: ______________

BIRTH DATE: ______________ AGE: _____ BIRTH WEIGHT: ____________ CURRENT WEIGHT: _____________

SEX: _______ NO. OF SIBLINGS: _____ BIRTH LENGTH: ____________ CURRENT LENGTH: ____________

TYPE OF BIRTH: NORMAL VAGINAL____ FORCEPS ____ BREECH ____ CESAREAN ____

PROBLEMS DURING PREGNANCY: ____

PROBLEMS DURING DELIVERY: ____

APGAR SCORES: ______ ______ WAS THERE PRESENCE AT BIRTH OF: ______ JAUNDICE (YELLOW)

______ CYANOSIS (BLUE)

CONGENITAL ANOMALIES/DEFECTS: ____

INFANT FEEDING: BREAST____________ BOTTLE___________ FORMULA____________

NO. OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD______ FAIR______ POOR_____

OBSTETRICIAN/MIDWIFE: ____
NAME LOCATED AT

PEDIATRICIAN/FAMILY MD: ____
NAME LOCATED AT

DATE OF LAST VISIT TO MD: _________________________________ PURPOSE: ___________________________

IMMUNIZATION HISTORY: ____

PURPOSE OF THIS APPOINTMENT: ____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? ____________________________________

DESCRIBE: ____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS PRACTICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: ___________________________ WITNESSED: _____________________________ DATE: ____________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS PRACTICE AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS PRACTICE.

DATE: _______________ SIGNATURE: ____

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY:

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DELIVERY/BIRTH HISTORY:

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DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD

_______________ RESPOND TO SOUND _______________ CRAWL

_______________ FOLLOW AN OBJECT WITH HIS/HER EYES _______________ STAND

_______________ HOLD HEAD UP _______________ WALK ALONE

_______________ SIT ALONE

CHILDHOOD DISEASES: _______________________ CHICKENPOX _______________________ RUBELLA

_______________________ MUMPS _______________________ ROSEOLA

_______________________ MEASLES _______________________ OTHER

HAS THIS CHILD EVER SUFFERED FROM:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Disorder
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Blood Disorders
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Problems
- ☐ Sugar Concentration
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Stomach Aches
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Muscle Jerking
- ☐ Ruptures/Hernia
- ☐ “Growing Pains”
- ☐ Other

PRESENT HISTORY:

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SURGERY: ____

MEDICATIONS: ____

ACCIDENTS:____

FAMILY HISTORY: ____