The Physician Network
Stevens Creek Family Medicine
1601 North 86th Street Suite 100
Lincoln, NE 68505
PH 402.327.7503
FX 402.327.7502

PEDIATRIC HISTORY

NAME:_____ DATE:_____

PLACE OF BIRTH:_____ DATE OF BIRTH: _____ AGE:_____

Present Problems: _____

_____

Current formula and amount per day (if using):_____

PAST HISTORY:

BIRTH WEIGHT_____ BIRTH LENGTH_____

PREGNANCY: Any complications during this child's pregnancy (bleeding, infection, toxemia)?

_____

LABOR: Any complications during this child's labor (breech, prolonged, baby's heart rate slow)?

_____

DELIVERY: Any problems during this child's delivery (C-Section, forceps, heavy bleeding, premature, late)?

_____

HOSPITAL: Any problems during this child's hospital stay (yellow jaundice, trouble with formula, infections)?

_____

ALLERGIES: Is the child allergic to:

Penicillin	Yes	No
Sulfa	Yes	No
Latex	Yes	No

Other (Please specify)?_____

OPERATIONS: List any operations this child has had and dates performed:

_____ _____ _____

_____ _____ _____

OTHER HOSPITALIZATIONS/ILLNESSES:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

IMMUNIZATIONS: (List dates)

DPT: 1st_____ 2nd_____ 3rd_____ 4th_____ 5th_____

Polio: 1st_____ 2nd_____ 3rd_____ 4th_____ 5th_____

MMR: 1st_____ 2nd_____

HIB: 1st_____ 2nd_____ 3rd_____ 4th_____

HEP: 1st_____ 2nd_____ 3rd_____

REVIEW OF SYSTEMS:

Has this child had any of the following problems (Include both past and present)

GASTROINTESTINAL:

Indigestion or heartburn	Y / N
Ulcers	Y / N
Frequent abdominal pain	Y / N
Vomiting blood	Y / N
Hepatitis or liver problems	Y / N
Gallbladder problems	Y / N
Frequent diarrhea	Y / N
Frequent constipation	Y / N
Rectal problems or bleeding	Y / N
Black tar-like bowel movements	Y / N
Recent change in bowel habits	Y / N
Other_____	Y / N

URINARY:

Kidney or bladder infection	Y / N
Kidney stones	Y / N
Burning with urination	Y / N
Difficulty passing urine	Y / N
Difficulty controlling urine	Y / N
Getting up at night to urinate	Y / N
Blood in urine	Y / N
Other_____	Y / N

GENITALIA:

Undescended testes	Y / N

BEHAVIOR:

School problems	Y / N
Sleep difficulty	Y / N
Nightmares/terrors	Y / N
Unusual fears	Y / N
Problems playing with other children	Y / N
Poor appetite	Y / N
Temper tantrums	Y / N

DEVELOPMENT:

Age this child:

Sat up alone _____

Crawled _____

Walked _____

Talked in phrases _____

Patient Name: _____ DOB: _____

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GENERAL:

Anemia	Y / N
Recent weight change	Y / N
Thyroid problems	Y / N
Diabetes or high blood sugar	Y / N
Frequent fever or chills	Y / N
Frequent large lymph glands or lumps	Y / N
Other_____	Y / N

SKIN:

Frequent rashes	Y / N
Changing mole	Y / N
Other_____	Y / N

HEAD:

Frequent headaches	Y / N
Visual problems not corrected by glasses	Y / N
Glaucoma	Y / N
Frequent dizziness	Y / N
Fainting	Y / N
Epilepsy or seizures	Y / N
Weakness in arm or leg	Y / N
Numbness	Y / N
Frequent ear infections	Y / N
Hearing difficulty	Y / N
Ringing in ears	Y / N
Frequent nose bleeds	Y / N
Frequent nasal congestion	Y / N
Difficulty swallowing	Y / N
Persistent hoarseness	Y / N
Other_____	Y / N

LUNGS:

Severe shortness of breath	Y / N
Asthma or emphysema	Y / N
Frequent cough	Y / N
Coughing up blood	Y / N
Tuberculosis	Y / N
Other_____	Y / N

HEART:

High blood pressure	Y / N
Rheumatic fever	Y / N
Chest pain or pressure	Y / N
Irregular heart beat	Y / N
Swelling in legs	Y / N
Other_____	Y / N

Patient Name: _____ DOB: _____