

## PEDIATRIC HISTORY SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pregnancy Complications: \_\_\_\_\_

Delivery type: \_\_\_\_\_ Problems: \_\_\_\_\_

Apgars Score: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Conditions First 24 Hours: \_\_\_\_\_ First Week: \_\_\_\_\_

Feeding: Breast: \_\_\_\_\_ Formula Type: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Sugeries: \_\_\_\_\_

Illnesses: \_\_\_\_\_

Pets: Y/N List: \_\_\_\_\_ Smoking Y/ N / S\_\_ Fire Place Y / N/ S\_\_

House Location: City \_\_\_\_\_ Country \_\_\_\_\_

Environmental Exposures (Industrial/ Trains/ Cell towers exc.) \_\_\_\_\_

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### Developmental History

Started Solids: \_\_\_\_\_ Walked: \_\_\_\_\_

Motor Skills \_\_\_\_\_

Speech/ Language \_\_\_\_\_

Hearing: \_\_\_\_\_

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### Family Members

Mother: Age \_\_\_\_\_ Health: \_\_\_\_\_ Occupation \_\_\_\_\_ Married/ Single

Father: Age: \_\_\_\_\_ Health: \_\_\_\_\_ Occupation \_\_\_\_\_ Married/ Single

Siblings: \_\_\_\_\_

Sibling Health Concerns if any: \_\_\_\_\_

### Family History

Allergies/ Hay Fever \_\_\_\_\_ Asthma \_\_\_\_\_

Eczema/ Skin Problems \_\_\_\_\_

HTN/ Heart Disease \_\_\_\_\_

Diagnosed at Age 55 or less: Diabetes: \_\_\_\_\_ Kidney Disease: \_\_\_\_\_

Bleeding Disorder: \_\_\_\_\_ Anemia: Y / N Autoimmune Disease \_\_\_\_\_

Seizures / Epilepsy \_\_\_\_\_ Cancer \_\_\_\_\_

Other: \_\_\_\_\_

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