

**SOUTH LAKE PEDIATRICS
PAST HEALTH AND FAMILY HISTORY (10 YEARS AND OLDER)**

PATIENT NAME: _____ M _____ F _____ DATE: _____

DATE OF BIRTH: _____ COMPLETED BY: _____

Welcome to South Lake Pediatrics. Please complete this form as thoroughly as possible. It will provide us with valuable information about your child and his/her health. This will help us to get to know your child more quickly and allow time for your questions and the information we would like to share with you. Thank you.

Child's previous or referring physician: _____

City / State: _____

If referred, reason for referral: _____

INFANT HISTORY

Number of living children today: _____

Delivery: (circle)

Full term Premature Birthweight _____

Vaginal C-section, reason: _____

Any maternal complications of labor, delivery or newborn period: _____

Please list any infant conditions or problems (e.g. infection, heart murmurs, jaundice, physical abnormalities): _____

Is this child adopted: NO YES Adoption Date: _____

CHILD'S ILLNESS HISTORY

NO YES

If yes, explain:

Allergies (medications, etc.)

Asthma

Chicken pox

Tonsillitis

Frequent sore throats

Ear infections

Lung / breathing problems

Serious Injuries

Hospitalized

Operations (specify)

Immunizations up to date

Other

PLEASE COMPLETE BOTH SIDES OF FORM

SOUTH LAKE PEDIATRICS

PATIENT NAME: _____

DEVELOPMENT / BEHAVIORAL HISTORY

Do you have any concerns about:	NO	YES	If yes, explain:
Language skills	_____	_____	_____
Motor skills:			
large muscle coordination	_____	_____	_____
hand / finger coordination	_____	_____	_____
Social skills:			
at home (with parents, siblings, peers)	_____	_____	_____
at school	_____	_____	_____
Behavior	_____	_____	_____
Discipline issues	_____	_____	_____
Current school grade:	_____	/ N/A _____	
School performance	_____	_____	_____

FAMILY HISTORY

Please check all the conditions which exist in your child's family, including grandparents, aunts, uncles, cousins, siblings, and parents. (Please specify)

CONDITION:	NO	YES	If yes, explain (who / what):
Allergies (medications, etc.)	_____	_____	_____
Asthma	_____	_____	_____
Birth defects	_____	_____	_____
Bladder / kidney disease or infection	_____	_____	_____
Bowel (ulcer, colitis, etc.)	_____	_____	_____
Cancer	_____	_____	_____
Chemical problems (alcohol, tobacco, marijuana, cocaine, etc.)	_____	_____	_____
Diabetes mellitus	_____	_____	_____
Ear problems / infections	_____	_____	_____
Eczema / psoriasis	_____	_____	_____
Emotional problems (nervous breakdown, suicide, etc.)	_____	_____	_____
Hearing problems (hearing aid, etc.)	_____	_____	_____
Heart problems (congenital, heart attack, murmur, etc.)	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Infant or childhood deaths	_____	_____	_____
Learning problems (mental retardation, dyslexia, etc.)	_____	_____	_____
Lung problems (emphysema, tuberculosis, cystic fibrosis, etc.)	_____	_____	_____
Obesity	_____	_____	_____
Seizure disorder (epilepsy, etc.)	_____	_____	_____
Thyroid problems	_____	_____	_____
Vision problems (blindness, lazy eye, cataract, etc.)	_____	_____	_____
Any chronic condition or unusual diseases not mentioned	_____	_____	_____
Mother's general health:	_____		Father's general health: _____

PLEASE COMPLETE BOTH SIDES OF FORM

Date	Physician review	Date	Physician review	Date	Physician review