

# Burlington Pediatrics

# Pediatric History Form

Child's Name: \_\_\_\_\_

Child's Birthday: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Chart Number: *(office use only)* \_\_\_\_\_

Please use designated space below to explain answers.

		Where did your child receive previous medical care? _____
Yes	No	Was pregnancy normal? _____
Yes	No	Were labor and delivery normal? _____
Yes	No	Were there complications in the nursery? _____
Yes	No	Was your child delivered via cesarean section? _____
** Yes	No	Was your child delivered at full term (40 weeks)? If no, how many weeks pregnant was mother at delivery? _____
		What was your child's weight at birth? _____
Yes	No	Does your child have any chronic illnesses such as asthma, diabetes, seizures? _____
		_____
Yes	No	Does your child take any medications? _____
Yes	No	Does your child have any allergies to medicines? _____
		_____
Yes	No	Has your child ever been hospitalized or had surgery? _____
		_____
Yes	No	Are there any smokers in the home? _____
Yes	No	Are there any pets in the home? _____
Yes	No	Do you consider your child to be healthy? _____
		_____

*Have any of your child's family members been diagnosed with the following:*

Allergies	Yes	No	Whom? _____
Anemia, Asthma, Birth Defects	Yes	No	Whom? _____
Bleeding Problems	Yes	No	Whom? _____
Breathing Problems	Yes	No	Whom? _____
Cancer	Yes	No	Whom? _____
Convulsions/Seizures	Yes	No	Whom? _____
Deafness	Yes	No	Whom? _____
Depression	Yes	No	Whom? _____
Developmental Delay	Yes	No	Whom? _____
Diabetes	Yes	No	Whom? _____
Heart Disease	Yes	No	Whom? _____
Hyperactivity	Yes	No	Whom? _____
Kidney Problems	Yes	No	Whom? _____
Tuberculosis	Yes	No	Whom? _____

\*\* If patient was born at 35 weeks gestation or less send chart to synagis coordinator.