Name _____

Date: _____

Child's Past Medical History for Andorra Pediatrics Electronic Medical Records

Please fill out the information below to help us to provide the best care for your child. Thank you.

Has your child ever had:

Blood Problems

1. Anemia (Iron deficiency, Sickle Cell, Thalassemia) ___ No ___Yes
2. Blood transfusions ___ No ___Yes
3. Chicken pox (Varicella) ___ No ___Yes
4. Contusions/Bruising ___ No ___Yes
5. Convulsions ___ No ___Yes
6. Fractures ___ No ___Yes
7. German Measles (Rubella) ___ No ___Yes
8. Measles (Rubeola) ___ No ___Yes
9. Meningitis ___ No ___Yes
10. Mumps ___ No ___Yes

Ears

1. Any hearing problems? ___ No ___Yes
2. Three or more ear infections? ___ No ___Yes

Eyes

1. Any visual problems? ___ No ___Yes
2. Do eyes look crossed? ___ No ___Yes
3. Does the child wear eyeglasses? ___ No ___Yes

Nose

1. Does the child have frequent attacks of sneezing or rubbing his/her nose? ___ No ___Yes
2. Has the child had frequent nose bleeds? ___ No ___Yes

Throat

1. Does your child have three or more strep throat infections per year? ___ No ___Yes

Heart

Have you ever been told your child has the following:

1. A heart murmur? ___ No ___Yes
2. Heart defect? ___ No ___Yes
3. High blood pressure? ___ No ___Yes

Lungs

Has your child ever had:

1. Asthma/wheezing? ___ No ___Yes
2. Bronchitis or pneumonia? ___ No ___Yes
3. Chronic cough? ___ No ___Yes
4. Does your child tire easily? ___ No ___Yes

Abdomen

Has your child ever had:

1. Blood in bowel movement? ___ No ___Yes
2. Difficulty with appetite or eating? ___ No ___Yes
3. Frequent abdominal pain? ___ No ___Yes
4. Frequent vomiting or diarrhea? ___ No ___Yes
5. Jaundice? ___ No ___Yes
6. Marked weight loss? ___ No ___Yes If yes, please explain:_____

Kidney

1. Does your child ever complain of burning or frequency of urination? ___ No ___Yes
2. Does your child wet the bed? ___ No ___Yes
3. Has there ever been blood in the urine? ___ No ___Yes
4. Has your child ever had a urinary tract infection? ___ No ___Yes

Skin

1. Acne? ___ No ___Yes
2. Any sensitivity or allergy? ___ No ___Yes
3. Eczema or atopic dermatitis? ___ No ___Yes

Extremities

Has your child:

1. Had weakness or paralysis of arms or legs? ___ No ___Yes
2. A persistent limp? ___ No ___Yes
3. Every worn corrective shoes or braces? ___ No ___Yes

Neurological

Has your child ever had:

1. Breath-holding? ___ No ___Yes
2. Convulsions or seizures? ___ No ___Yes
3. Dizziness? ___ No ___Yes
4. Fainting? ___ No ___Yes
5. Frequent headaches? ___ No ___Yes
6. Temper tantrums? ___ No ___Yes

Is your child:

1. Impulsive? ___ No ___Yes
2. Lacking in self-control? ___ No ___Yes
3. Overactive? ___ No ___Yes

Does your child have problems with:

1. Attending school? ___ No ___Yes
2. Attention span? ___ No ___Yes
3. Learning? ___ No ___Yes
4. Mood? ___ No ___Yes
5. Parents? ___ No ___Yes
6. Peers? ___ No ___Yes
7. Siblings? ___ No ___Yes
8. Sleep? ___ No ___Yes

Hospitalizations: If yes, what illness___ No ___Yes _____

Operations- If yes, what illness? ___ No ___Yes _____

1. **Poison ingestion** ___ No ___Yes _____
2. **Is your child currently taking any Medications, Vitamins or Herbs**? ___ No ___Yes _____

   Medication Strength/Dose How Often Given? _____
3. **Reaction to medication or food** (allergy) If yes, please explain ___ No ___Yes _____
4. **Any chronic or recurring pain?** ___ No ___Yes If yes, please explain: _____
5. Other **serious medical illnesses** If yes, what kind? ___ No ___Yes _____

   _____

Social Histroy

Who lives in home? Name – Relationship – Date of Birth

_____

Who is the primary caregiver: ___ Mother/Father ___ Mother ___ Father ___Other _____
Are child's parents: ___ Married ___ Unmarried ___ Separated ___ Divorced
Does anyone in home smoke? ___ No ___ Yes Who: _____
Parent's occupation: _____
Smoke Detectors in home: ___ Yes ___ No Guns in home: ___ No ___ Yes Locked up: ___ Yes ___ No
Pets? _____
Are there concerns about physical, sexual or emotional abuse? ___ No ___Yes _____
Any other concerns you would like to discuss? _____

_____

Birth History

Birth weight: ____lb. ____ oz. Time of Birth: _____ AM PM Apgar Score: ____/____

Full term/Premature _____weeks gestation Hospital: _____

Jaundice: ___ No Yes: _____ Phototherapy: ___ No ___ Yes Bilirubin Level: _____

Delivery: Vaginal/C-Section (why): _____

Maternal illness during or after pregnancy: _____

Mom's Blood Type A—B--AB—0 Rh: + / - Baby's Blood Type: A—B--AB—0 Rh: + / - Coombs Test: - / +

Any problems with baby in hospital: ___ No Yes _____

Hearing Screen: ___ Passed ___ Not Passed Repeated? Y / N

Newborn Screen done in Hospital/Birth Center? ___ Yes ___ No