PEDIATRIC CARE of KENTUCKY 6-21-12

PAST HISTORY

PATIENT NAME: _____

Does your child have, or has he/she ever had:

Chickenpox	___YES	___NO	COMMENTS_____
Frequent ear infections	___YES	___NO	COMMENTS_____
Problems with ears or hearing	___YES	___NO	COMMENTS_____
Nasal allergies	___YES	___NO	COMMENTS_____
Problems with eyes or vision	___YES	___NO	COMMENTS_____
Asthma, bronchitis, bronchiolitis, or pneumonia	___YES	___NO	COMMENTS_____
Any heart problem or heart murmur	___YES	___NO	COMMENTS_____
Anemia or bleeding problem	___YES	___NO	COMMENTS_____
Blood transfusion	___YES	___NO	COMMENTS_____
Frequent abdominal pain	___YES	___NO	COMMENTS_____
Constipation requiring doctor visits	___YES	___NO	COMMENTS_____
Bladder or kidney infection	___YES	___NO	COMMENTS_____
Bed-wetting (after 5 years old)	___YES	___NO	COMMENTS_____
(For Girls) Has she started her menstrual periods?	___YES	___NO	COMMENTS_____
(For Girls) Are there problems with her periods?	___YES	___NO	COMMENTS_____
Any chronic or recurrent skin problem (acne, eczema, etc)	___YES	___NO	COMMENTS_____
Frequent headaches	___YES	___NO	COMMENTS_____
Convulsions or other neurological problems	___YES	___NO	COMMENTS_____
Diabetes	___YES	___NO	COMMENTS_____
Thyroid or other endocrine problem	___YES	___NO	COMMENTS_____
Any other significant problem	___YES	___NO	COMMENTS_____
Use of alcohol or drugs	___YES	___NO	COMMENTS_____

This form has been completed by:_____ Relationship to child_____ Date _____

PEDIATRIC CARE of KENTUCKY 7-22-14

PATIENT NAME: _____

Has any family member (parents, siblings, paternal/maternal grandparents) had the following:

ADD/ADHD	WHO_____	COMMENTS_____
Allergies	WHO_____	COMMENTS_____
Asthma	WHO_____	COMMENTS_____
Birth Defects	WHO_____	COMMENTS_____
Cancer	WHO_____	COMMENTS_____
Coronary artery disease before 50 yrs	WHO_____	COMMENTS_____
DDH (hip dysplasia)	WHO_____	COMMENTS_____
Deafness	WHO_____	COMMENTS_____
Depression	WHO_____	COMMENTS_____
Developmental delay	WHO_____	COMMENTS_____
Diabetes	WHO_____	COMMENTS_____
Eczema	WHO_____	COMMENTS_____
Genetic disorder	WHO_____	COMMENTS_____
Hemoglobinopathy (i.e.sickle cell)	WHO_____	COMMENTS_____
Hyperlipidemia (high cholesterol)	WHO_____	COMMENTS_____
Hypertension (high blood pressure)	WHO_____	COMMENTS_____
Learning disability	WHO_____	COMMENTS_____
Mental Retardation	WHO_____	COMMENTS_____
Migraines	WHO_____	COMMENTS_____
Obesity	WHO_____	COMMENTS_____
Scoliosis	WHO_____	COMMENTS_____
Seizure disorder	WHO_____	COMMENTS_____
SIDS (sudden infant death syndrome)	WHO_____	COMMENTS_____
Strabismus (eyes cross)	WHO_____	COMMENTS_____
Thyroid disease	WHO_____	COMMENTS_____
Drug/Alcohol abuse	WHO_____	COMMENTS_____
Immune problem, HIV, AIDS	WHO_____	COMMENTS_____
Bleeding disorder	WHO_____	COMMENTS_____
Mental illness	WHO_____	COMMENTS_____
Other	WHO_____	COMMENTS_____

Additional family history _____

_____

_____