



South River Pediatrics

Pediatric History

| | |
|---|-----------------------------------|
| Name: _____ | Date of Birth: _____ |
| Name of person completing form/relation to child: _____ | |
| Allergies/Medications: _____ | |
| Hospitalizations? _____ | Date: _____ |
| Serious Injuries? _____ | Date: _____ |
| Number of hour's child sleeps per night: _____ | Naps? _____ |
| Child lives with (residentially)/Ages _____ | |
| Daycare? Y/N If in school, grade _____ Problems? _____ | |
| Teacher feedback /Report Card: _____ | |
| Activities/Exercise? _____ | |
| Amount of TV per day: _____ | |
| Disciplinary/Behavior Problems? _____ | Any guns in the house? Y/N |
| Other concerns (abnormal growth/development) _____ | |

Family Medical History

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|--|
| Congenital/Family Diseases: _____ |
| Early Heart Disease/Cholesterol problems: _____ |
| Other family medical concerns: _____ |
| Lead Exposure (homes built prior to 1960/siblings w/ lead poisoning: _____ |

For Newborns/ First Visits

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|---|------------------------------|
| Place of Birth: _____ | |
| Number of weeks into the pregnancy when birth occurred: _____ | |
| Birth Weight: _____ | Birth Length: _____ |
| Delivery (Vaginal/Cesarean): _____ | Discharged after _____ Days. |
| Problems during pregnancy? Y/N Comments _____ | |
| Problems during deliver? Y/N Comments _____ | |
| Alcohol/Drug Use/ Smoking during pregnancy? _____ | |
| Hepatitis B immunization? Y/N _____ | PKU? Y/N _____ |

For Adolescents

| | | |
|---|--|--------------------|
| Age at first period _____ | Date of last period _____ | Pregnancies? _____ |
| Sexually Active? Y/N If yes, please complete the following information: Birth Control: _____ | | |
| Number of sexual partners _____ | History of Sexually Transmitted Disease? _____ | |
| Drug Use? (Current/Past) _____ | History of suicidal thoughts/attempts? _____ | |

Any other issues you would like to discuss? _____

