Pediatrics
"TLC for your kids"

Date _____

Patient's Name _____ Sex _____ Phone _____

Birth History

DOB _____
Birth Hospital _____
Birth Weight _____
Pregnancy Complications _____
Delivery Compliations _____

Past Medical History

Allergies _____
Medications _____
Hospitalizations _____
Surgeries _____
Medical Problems _____

Notes: _____

Social History

Mother's Name _____ Marital Status ☐M ☐S ☐D ☐Remarried
Occupation _____ Age _____
Father's Name _____ Marital Status ☐M ☐S ☐D ☐Remarried
Occupation _____ Age _____
Siblings' Name and ages: _____

Family History

Circle any medical conditions that run in your immediate family

anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, mental illness, inherited illness, cancer, tuberculosis, drug problems, alcohol problems

List any others: _____

Development

	YES	NO
Are you conerned about your child's behavior or development?	☐	☐
Does your child have trouble in school?	☐	☐

If yes, please explain _____

Safety

Does your child use his/her seat belt or car seat (under age 8)	☐	☐
Does your child use his/her bicycle helmet?	☐	☐
Is there a swimming pool?	☐	☐
Are there smokers in the household?	☐	☐
Are there firearms in your house?	☐	☐
Are there any pets in the house?	☐	☐

Immunizations

Do you have a record of your child's immunizations?	☐	☐
Is it up to date?	☐	☐

Health Care Maintenance

Is your child currently in good health?	☐	☐
If no, explain _____		
Do you have any concerns about your child?	☐	☐
If yes, explain _____		