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

	YES	NO
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

	YES	NO
Do you have a record of your child's immunizations?	☐	☐
Is it up to date?	☐	☐

Health Care Maintenance

	YES	NO
Is your child currently in good health?	☐	☐

If no, explain ______________________

	YES	NO
Do you have any concerns about your child?	☐	☐

If yes, explain ______________________