5303 Plaza Dr.
Suite 106
Hopewell, VA 23860
Office: 804-520-0002
Fax: 804-520-2259
admin@caldwellpediatrics.com

Patient History

Name:____

Acc. Number: _________________________________

Birth date:_________________Age________________

Form completed by: ___________________________

Date completed: ______________________________

HOUSEHOLD:

Please list all those living in the child's home:

NAME	RELATIONSHIP TO CHILD	BIRTHDATE	HEALTH PROBLEMS

Are there any siblings not listed? If so, please list their names and ages and where they live: ______________

____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

____.

If one or both parents are not living in the home, how often does he/she see the parent/s not in the home?

____.

BIRTH HISTORY:

Birth weight:_________________Method of delivery:_________vaginal_________cesarean

If by cesarean section, why:____.

Was the baby born term:__________________early:_____________if early, how many weeks:___________.

Did your baby have any problems right after birth?________Yes__________No

If yes, explain problems:____.

Did mother have any illness or problems with her pregnancy:_________Yes__________No

If yes, explain:____.

How was baby fed initially? breast____________bottle___________________

During pregnancy, did mother smoke:____________Yes____________No

Drink alcohol_________Yes_______No / Use drugs or medications:_________Yes_______No

If yes, what medications or drugs were used: ____

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Was the baby discharged home with the mother:__________Yes_______________No

If no, explain____.

GENERAL:

Do you consider your child to be in good health?_____Yes_____No Explain ___________________________

Does your child have any serious illness or medical conditions:?______Yes______No Explain ____________

Has your child had serious injuries or accidents?______Yes______No Explain _________________________

Has your child had any surgery?______Yes______No Explain _____________________________________

Has your child ever been hospitalized?______Yes_______No Explain _______________________________

Is your child allergic to any medicines or drugs?_______Yes_______No Explain______________________

DEVELOPMENT:

Are you concerned about your child's physical development?______Yes_____No Explain______________

Are you concerned about your child's mental or emotional development?____Yes____No Explain_________

Are you concerned about your child's attention span?_____Yes_____No Explain______________________

If your child is in school:

How is his/her behavior in school? ____

Has he/she failed or repeated a grade in school? ____

How is he/she doing in academic subjects? ____

Is he/she in special or resource classes? ____

FAMILY HISTORY:

Have any members of the family had the following:

Deafness	Yes_____No_____Who__________________
Nasal allergies	Yes_____No_____Who__________________
Asthma	Yes_____No_____Who__________________
Tuberculosis	Yes_____No_____Who__________________
Heart disease (before 50 years old)	Yes_____No_____Who__________________
High blood pressure (before 50 y.o.)	Yes_____No_____Who__________________
High cholesterol	Yes_____No_____Who__________________
Anemia	Yes_____No_____Who__________________
Bleeding disorder	Yes_____No_____Who__________________
Liver disease	Yes_____No_____Who__________________
Kidney disease	Yes_____No_____Who__________________
Diabetes (before 50 y.o.)	Yes_____No_____Who__________________
Bed-wetting (after 10 y.o.)	Yes_____No_____Who__________________
Epilepsy or convulsions	Yes_____No_____Who__________________

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Alcohol abuse? Yes____No____Who________________

Drug abuse? Yes____No____Who________________

Mental illness? Yes____No____Who________________

Mental retardation? Yes____No____Who________________

Immune problems, HIV or AIDS? Yes____No____Who________________

Additional family history or comments: ____

____.

____.

PATIENT HISTORY:

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

Chickenpox: Yes___No____When___________________________

Frequent ear infections: Yes___No____Explain___________________________

Problems with ears or hearing: Yes___No____Explain___________________________

Nasal allergies: Yes___No____Explain___________________________

Problems with eyes or vision: Yes_No_Explain_________________________________

Asthma, bronchitis, bronchiolitis, pneumonia: Yes__No__Explain______________________________

Any heart problem or heart murmur: Yes___No____Explain___________________________

Anemia or bleeding problems: Yes___No____Explain___________________________

Blood transfusions: Yes___No____Explain___________________________

Frequent abdominal pain: Yes___No____Explain___________________________

Constipation requiring doctor visits: Yes___No____Explain___________________________

Bladder or kidney infections: Yes___No____Explain___________________________

Bed-wetting (after 5 y.o.): Yes__No__Explain______________________________

(For girls) has she started menstrual period? Yes__No__When_______________________________

(For girls) are there problems with period? Yes__No__Explain______________________________

Any chronic or recurrent skin problems (Acne, eczema, etc)? Yes_No_Explain__________________________________

Frequent headaches: Yes_No_Explain_________________________________

Convulsions or other neurologic problems: Yes_No_Explain_________________________________

Diabetes: Yes___No____Explain___________________________

Thyroid or other endocrine problems: Yes___No____Explain___________________________

Any other significant problem: Yes___No____Explain___________________________

Use of alcohol or drugs: Yes___No____Explain___________________________