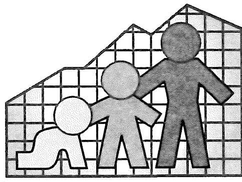

HENDERSONVILLE PEDIATRICS, PA

CHILD'S FULL NAME: ______________________________

DATE OF BIRTH: ____________________ CHART #:______________

BIRTH HISTORY

Pregnancy: ❑ Healthy ❑ Problems

Group B Strep Satus: ❑ Positive ❑ Negative Antibiotics given: ❑ Yes ❑ No

Birth Weight: ______ lbs ______ oz

Gestational Age: __________ wks OR ❑ Term ❑ Preterm

Delivery: ❑ Vaginal ❑ C-section

Infection: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ No *If Yes*: Bili-lites? ❑ Yes ❑ No

Circumcision: ❑ Yes ❑ No

Diet: ❑ Breast ❑ Formula

Other Complications:______________________________

CHILD'S PAST MEDICAL HISTORY (Please circle all that apply)

ADHD
Allergies
Arthritis
Asthma
Anemia
Bedwetting
Bronchiolitis/Bronchitis
Burn
Cavities
Cerebral Palsy
Chicken Pox
Constipation
Depression

Development Delay
Diabetes
Ear Infections
Fracture
Gastric Reflux
Head Injury
Hearing Impairment
Heart Disease
Heart Murmur
History of Child Abuse
Ingestion of Poison
Learning Difficulty
Menstrual Problem

Migraine Headaches
Mononucleosis
Pneumonia
Seizure/Epilepsy
Sickle Cell Anemia
Sinusitis
Speech Delay
Strep Throat
Visual Disturbance (glasses)
Other: ______________
Other: ______________
Other: ______________

HOSPITALIZATIONS:

Date/Age: ______________ Reason: ______________

Date/Age: ______________ Reason: ______________

SURGERIES:

Date/Age: ______________ Reason: ______________

Date/Age: ______________ Reason: ______________

CURRENT MEDICATIONS:

1: ______________ 3: ______________

2: ______________ 4: ______________

PLEASE CONTINUE ON BACK OF SHEET

ALLERGY HISTORY (Please circle all that apply)

Animals
Bees
Dust/Dust Mites
Egg White
Milk
Mold
Nuts
Pollen
Shellfish
Soy
Tobacco
Wasps

Other: ______________________________

Allergies to Medications:

Medication: ____________________ Reaction: ____________________
Medication: ____________________ Reaction: ____________________
Medication: ____________________ Reaction: ____________________

SOCIAL HISTORY

Activities/Sports: ______________________________

Daycare/Preschool/School: ______________________________

Environment:

Home over 20 yrs old: ❑ Yes ❑ No Water: ❑ City ❑ Well
Tobacco smoke exposure: ❑ Yes ❑ No Pets: ____________________

Safety/Self Care:

Firearms in home: ❑ Yes ❑ No Firearms Locked: ❑ Yes ❑ No
Car Seat ❑ Yes ❑ No Seatbelt: ❑ Yes ❑ No
Helmet use: ❑ Yes ❑ No
Brushes teeth daily: ❑ Yes ❑ No Dental Care: ❑ Yes ❑ No

Family Constellation:

Current Household Members: ______________________________
Custody (if other than both parents): ______________________________

FAMILY HISTORY
(Please make a check mark (✔) for all that apply)

Disease	Mom	Dad	Sister	Brother	Mom's Family	Dad's family
Allergies						
Asthma						
Blood Diseases						
Cancer (state type)						
Birth Defects						
Diabetes						
Gastrointestinal						
Hearing Impairment						
Heart Disease						
High Blood Pressure						
Joint Disease						
Kidney Disease						
Liver/Gall Bladder						
Muscle/Bone Disease						
Neurologic/Seizures						
Psychiatric						
Thyroid Disease						
Visual Disturbance						