



NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC
Pediatric Patient History - 0-12 Years

Date Last Name First Name Age DOB

Patient History Reviewed (mm/yy):

Child's Name Age Today Date

Previous Physician Address

BIRTH HISTORY: Adopted? Yes No If Yes, is child aware? Yes No

Date of Birth Hospital

Problems during pregnancy? Yes No If Yes, please list:

Full-Term or Premature

Type of Delivery: Vaginal C-Section Complications

Regular Nursery? Yes No

NICU or Special Care Nursery? Yes No, If Yes, reason:

Birthweight Length Head Circumference

If known - Apgar Score - 1 minute 5 minute

Problems After Birth or During First Week (0 = None)

Breathing Problems

Convulsions (Seizure)

Jaundice If Yes, was treatment needed?

Feeding Problems

Heart Problems

Hip Problems

Others

ALLERGY: Does your child have allergies? Yes No

IMMUNIZATION: Did you bring your child's immunization record? Yes No

SOCIAL HISTORY:

Mother's Name Age Health

Occupation Education (Last Grade)

Father's Name Age Health

Occupation Education (Last Grade)

Brother/Sister Age Health

Brother/Sister Age Health

Brother/Sister Age Health

Brother/Sister Age Health

Who does child live with? Mother Father Both Brother(s)/Sister(s)

Other (who)

Parents' Marital Status: Married Divorced* Never Married Separated Widowed

*If Divorced, who has legal custody?

Child's School Grade Grades: Above Ave Average Poor

Last Name _____ First Name _____ Age _____ DOB _____

PAST MEDICAL HISTORY: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fractures / Broken Bones | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Head Injury / Concussion | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bladder / Urine Infection | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Bowel Problem | <input type="checkbox"/> Hives / Skin Problems | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Infectious Mononucleosis (Mono) | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Strep Throat or Scarlet Fever |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Age at first menstrual period: _____ | <input type="checkbox"/> Wheezing or Asthma |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual Problem | |
| <input type="checkbox"/> Frequent ER visits: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list reason: _____ | | |

Previous Hospitalizations/ER Visits Yes No If yes, proceed to next line.

Give Name of Hospital, Type of Problem, Child's Age: _____

RISK FACTORS

Smokers in home? Patient: Yes _____ No _____ / Parents: Yes _____ No _____ / Sitter: Yes _____ No _____ /

Grandparents: Yes _____ No _____

Smoke Detector in home? Yes _____ No _____

Guns in home? Yes _____ No _____, If Yes, are they locked and unloaded? _____

Seat Belt Use: Yes _____ No _____ / Car Seat Use: Yes _____ No _____ / Use of Bike Helmets: Yes _____ No _____

FAMILY HISTORY

Medical Problems (Relatives of the Patient)	None	Mother	Father	Sister/ Brother	Grand- parent	Aunt/ Uncle	Great- Grandparent
Arthritis (Before Age 50)							
Asthma							
Bleeding Disorder							
Childhood Cancer							
Convulsions / Seizures							
Developmental Delay or Mental Retardation							
Diabetes / Sugar Diabetes							
Heart Disorder							
Heart Attack (Before Age 50)							
High Cholesterol							
History of Birth Defects in Family							
History of Sudden Infant Death ("SIDS") in family							
Hypertension (High Blood Pressure) (Before Age 50)							
Hypoglycemia (Low Blood Sugar)							
Kidney/Bladder Disorder							
Nerve or Muscle Disorder							
Stroke (Before Age 50)							
Tuberculosis (TB)							
Other / Comments							

Does your child have any pain now?: No Yes Does your child have any ongoing pain problems?: No Yes

Barriers to Learning: None Vision Hearing Cannot read Cannot comprehend

Language/need interpreter Other

How does the patient best learn: Pictures Reading Listening Demonstration Other _____

Do you have any concerns regarding your child's development (i.e., behavior, nutrition): _____

Any other concerns regarding your child?: _____

Signatures of parent/guardian/historian: _____ Date _____

Reviewed by Provider: _____ Date _____