

**Muddy Creek Pediatrics  
Initial History**

**Name of Patient** \_\_\_\_\_ **Sex:** \_\_\_ Male \_\_\_ Female **DOB** \_\_\_/\_\_\_/\_\_\_

**Form Completed By** \_\_\_\_\_ **Relation to patient** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

**Family**

Are mother and father  married  separated / divorced  other ?  
If separated/divorced, what is the patient's custody status?

If one or both parents are not living in the home, how often does

Child see that parent? \_\_\_\_\_

Are there siblings living away from home ?  Yes  No

If yes, give name, age and where they live: \_\_\_\_\_  
\_\_\_\_\_

List all family members in the patient's home			
Name	Relation	Birth Date	Health Problems
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

**Current Medical History**

Are immunizations up to date?  Yes  No

Is your child having any medical problems?  Yes  No

Do you consider your child to be in good health?  Yes  No

Current Medications:

Drug Allergies?  Yes  No

**Review of Systems and Past Medical History**

*Does the patient have or has ever had any of the following:*

1. a serious medical problem?
2. been hospitalized or had surgery?
3. had a serious injury or accident?
4. chickenpox? When? \_\_\_\_\_
5. allergies, asthma, bronchitis, respiratory infections?
6. repeated ear infections, tubes, difficulty with hearing?
7. heart problems or a heart murmur?
8. problems with eyes or vision?
9. anemia, bleeding problems or blood transfusion?
10. recurrent vomiting, recurrent diarrhea, blood in stools?
11. abdominal pain, constipation requiring doctor visits?
12. recurrent skin problems (acne, eczema, etc)?
13. bladder or kidney infections, bed-wetting after 5 years?
14. diabetes, thyroid or other endocrine problems?
15. headaches, convulsions, other neurologic problems?
16. If female, has she started her menstrual periods?

Yes	No	Explain
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
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<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

**If yes, is she having any problems?**

Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

**Development** *Are you concerned about the patient's...*

- 1. physical development?
- 2. attention span or activity level?
- 3. learning ability?
- 4. mental or emotional development?

**Yes**      **No**

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

*If in school, has the patient had...*

- 1. behavioral problems
- 2. placement in a special or resource class?
- 3. tutoring outside of the classroom?
- 4. to repeat a grade?
- 5. educational or psychological testing?

**Yes**      **No**

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

**Maternal and Newborn History**

**Pregnancy**      *Check if the mother had any of the following problems:*

- urinary infections    excessive wt. gain    excessive swelling    toxemia    venereal disease    rubella    none    other

Did the mother smoke, use alcohol or drugs during pregnancy?    Yes    No

**Birth**

Birth weight \_\_\_\_\_ Length \_\_\_\_\_ Apgar \_\_\_\_\_      Was baby born at:    Early    Late    Term  
If early, how many weeks gestation? \_\_\_\_\_      Was labor difficult or prolonged?       Yes    No

Was delivery complicated or difficult? \_\_\_\_\_

**Newborn**      *Check if the patient had any of the following problems:*

- feeding problems:    Breast \_\_\_\_\_       Formula \_\_\_\_\_
- slow weight gain    colic    jaundice    recurring diarrhea    recurring vomiting    blood in stools    multiple formula changes
- none    other \_\_\_\_\_

**Family History**      *If a family member has or has any of the following problems, check the appropriate box and list the family member:*

**M-Mother   F-Father   S-Sibling   GF-Grandfather   GM-Grandmother   A-Aunt   U-Uncle**

- |  |  |   |
|--|--|---|
| 1. <input type="checkbox"/> _____ Anemia/Blood disorders   | 12. <input type="checkbox"/> _____ Respiratory infections        | 23. <input type="checkbox"/> _____ Eczema         |
| 2. <input type="checkbox"/> _____ Ear infections/tubes     | 13. <input type="checkbox"/> _____ Stomach/GI                    | 24. <input type="checkbox"/> _____ Allergies      |
| 3. <input type="checkbox"/> _____ Epilepsy or convulsions  | 14. <input type="checkbox"/> _____ Tuberculosis                  | 25. <input type="checkbox"/> _____ Asthma         |
| 4. <input type="checkbox"/> _____ Eye or visual problems   | 15. <input type="checkbox"/> _____ Heart attack/stroke before 50 | 26. <input type="checkbox"/> _____ Arthritis      |
| 5. <input type="checkbox"/> _____ Hereditary problems      | 16. <input type="checkbox"/> _____ Heart problems, other         | 27. <input type="checkbox"/> _____ Deafness       |
| 6. <input type="checkbox"/> _____ High cholesterol         | 17. <input type="checkbox"/> _____ Immunity problems/HIB         | 28. <input type="checkbox"/> _____ Cancer         |
| 7. <input type="checkbox"/> _____ Drug/Alcohol abuse       | 18. <input type="checkbox"/> _____ Learning prob./Attn. span     | 29. <input type="checkbox"/> _____ Birth defects  |
| 8. <input type="checkbox"/> _____ Mental Retardation       | 19. <input type="checkbox"/> _____ Thyroid/other endocrine prob. | 30. <input type="checkbox"/> _____ Obesity        |
| 9. <input type="checkbox"/> _____ Migraine headaches       | 20. <input type="checkbox"/> _____ Emotional/behavioral          | 31. <input type="checkbox"/> _____ Liver disease  |
| 10. <input type="checkbox"/> _____ Diabetes before 50 yrs. | 21. <input type="checkbox"/> _____ High blood pressure before 50 | 32. <input type="checkbox"/> _____ Mental Illness |
| 11. <input type="checkbox"/> _____ Bladder/Kidney          | 22. <input type="checkbox"/> _____ Drug allergies                | 33. <input type="checkbox"/> _____ Other          |

Provider Comments: