

**SAN DIEGO SPORTS MEDICINE AND FAMILY HEALTH CENTER
PEDIATRIC HISTORY FORM**

Child's Name: _____ Age: _____ Date form filled out: _____

Medications (does your child take any now?)

Allergic Reactions (drugs, asthma, hives, eczema, hay fever)

Hospitalizations (when, where, why?)

Surgery (when, where, why?)

Serious Injuries (when, where?)

Birth History

Was pregnancy normal _____ Was baby full term _____

Was delivery normal _____ Any nursing problems _____

Family History

Birth Defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sudden infant death	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Allergy/hay fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eczema/recurrent rash	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cystic fibrosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart disease/stroke before age 50	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney/bladder problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach/bowel problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eye problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding during pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Hearing problem before age 50	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recurrent ear infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscle disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Back/hip problem before age 50	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Arthritis/joint problem before age 50	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Brain or nerve disease/seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Slow development	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Emotional/behavioral problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hyperactivity/inattention	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Learning disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol/drug/substance abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sexually transmitted diseases	<input type="checkbox"/> No	<input type="checkbox"/> Yes
AIDS/tuberculosis/hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Any pets at home?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Any smokers at home?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anyone physically abused?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anyone sexually abused?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Allergies/sensitivities	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Father living? _____ Age now _____ Health _____

Mother living? _____ Age now _____ Health _____

Brother/Sisters? _____ How many? _____

Ages _____ Health _____

General Survey - Has your child had any unusual problems with the following?

Discipline or behavior problem? No Yes

Ever seen by a Psychologist, Speech Therapist or Special Teachers? No Yes

Head _____

Eyes _____

Ears/Nose/Throat _____

Chest/Heart/Lungs _____

Stomach _____

Kidneys _____

Bladder _____

Bones/Muscles/Joints _____

Skin _____

Blood _____

When was your child's last blood test? _____

Any special comments about your child?

Your last doctor was?
