CENTRAL OHIO℠ PRIMARY CARE

Pediatric Comprehensive Patient History

☐ New Patient ☐ Established Patient Today's Date: _____

Parent(s) Name: _____

Child's Full Name: _____ Date of birth: _____ Sex ☐ M ☐ F

Child's Doctor: _____ Referred by: _____

Child's Medical History ☐ Unknown ☐ No Significant Medical History

Complete gray section if child is less than 5 years old or if there was a significant/complicated pregnancy history

Pregnancy/Birth History: *Check all that apply*
- ☐ Mother's age at delivery _____
- Month prenatal care began _____
- Weeks of pregnancy _____
- Birth Weight _____ ☐ C-Section ☐ Vaginal

Pregnancy Complications:
- ☐ Infections ☐ Diabetes ☐ Pre-eclampsia
- ☐ Multiple Gestations _____
- ☐ Other _____

Birth/Newborn Complications:
- ☐ Other _____
- ☐ Premature? – How early? _____
- ☐ NICU stay? – How long? _____

Medications: _____
- ☐ Infections _____

During pregnancy, the child's mother:
- ☐ Smoked - How much? _____
- ☐ Drank alcohol - How much? _____

Current Medications:

Allergies to Medicines:

Reaction:

This Child has been DIAGNOSED with:

☐ ADD/ADHD	Age:_____	
☐ Allergies/Hay fever	Age:_____	
☐ Anemia	Age:_____	
☐ Asthma	Age:_____	
☐ Autism	Age:_____	
☐ Bipolar Disorder	Age:_____	
☐ Blood Disorder/Sickle Cell	Age:_____	
☐ Broken Bones - Detail below		
_____	Age:_____	
_____	Age:_____	
☐ Cancer - Type: _____		
	Age:_____	
☐ Celiac Disease	Age:_____	
☐ Chicken Pox	Age:_____	
☐ Constipation	Age:_____	
☐ Depression	Age:_____	
☐ Developmental Delay	Age:_____	
☐ Diabetes	Age:_____	
☐ Frequent Ear Infections	Age:_____	
☐ Gastrointestinal disorder	Age:_____	
☐ Headaches/migraines	Age:_____	
☐ Learning Disability	Age:_____	
☐ Pneumonia	Age:_____	
☐ Scoliosis (curved spine)	Age:_____	
☐ Seizures/epilepsy	Age:_____	
☐ Skin Issues	Age:_____	
☐ Stomach Problems	Age:_____	
☐ UTI/Bladder Infections	Age:_____	
☐ Other _____		

Child's SURGERIES ☐ None

☐ Appendectomy	Age:_____	☐ Eye Surgery	Age:_____
☐ Adenoidectomy	Age:_____	☐ Hernia repair	Age:_____
☐ Ear Tubes	Age:_____	☐ Tonsillectomy	Age:_____
☐ Other _____	Age:_____		
☐ Other _____	Age:_____		

Child's Hospitalizations:
- Hospitalization: _____ Age: _____
- Hospitalization: _____ Age: _____
- Hospitalization: _____ Age: _____
- Hospitalization: _____ Age: _____

Child's Family History: Check the diagnoses given to the child's relatives. ☐ **Unknown**

Please circle relationship M=Mother, F=Father, S=Sibling(s), GM = Grandmother, GF=Grandfather, O=Other Relative(s)

Diagnosis of relative:	Relationship to child	Diagnosis of relative:	Relationship to child
☐ ADD	M F S GM GF O	☐ High Blood Pressure	M F S GM GF O
☐ Allergies	M F S GM GF O	☐ High Cholesterol	M F S GM GF O
☐ Anemia	M F S GM GF O	☐ Learning Disability	M F S GM GF O
☐ Asthma	M F S GM GF O	☐ Mental retardation	M F S GM GF O
☐ Autism	M F S GM GF O	☐ Psychiatric Illness (Depression, addiction, etc)	M F S GM GF O
☐ Blood Disorder/ Sickle Cell	M F S GM GF O	☐ Seizures/epilepsy	M F S GM GF O
☐ Cancer	M F S GM GF O	☐ SIDS (crib death)	M F S GM GF O
☐ Celiac Disease	M F S GM GF O	☐ Stroke before age 55	M F S GM GF O
☐ Diabetes	M F S GM GF O	☐ Sudden Death before age 50	M F S GM GF O
☐ Gastrointestinal disorder	M F S GM GF O	☐ Other _____	M F S GM GF O
☐ Heart disease before age 55	M F S GM GF O		

Social/Environmental

Child lives w/:
- ☐ Parent(s): ☐ Together ☐ Apart/Shared
- ☐ Mother
- ☐ Father
- ☐ Relative _____
- ☐ Other _____

Adopted ☐

Smokers live in home with child?	☐ Yes	☐ No
Child attends day care?	☐ Yes	☐ No
Pets in the home?	☐ Yes	☐ No
Well water?	☐ Yes	☐ No
Home built before 1960?	☐ Yes	☐ No

Other _____