Stanford Hospital and Clinics
Stanford Family Medicine

PEDIATRIC HISTORY

(addressograph stamp)

Date Completed _____ Date of Birth _____

Note: Please complete all items, marking "no" or "none" for each section or item if it does NOT apply to you.

ILLNESS AND INJURIES

Have you ever had:

Yes	No	
☐	☐	Mumps
☐	☐	Measles
☐	☐	German measles
☐	☐	Chickenpox
☐	☐	Seizures
☐	☐	Asthma
☐	☐	Allergies
☐	☐	Poison ingestion
☐	☐	Broken bone(s)
☐	☐	Knocked unconscious
☐	☐	Tonsillitis
☐	☐	Urinary tract infection
☐	☐	Ear infection(s)
☐	☐	Pneumonia
☐	☐	Meningitis
☐	☐	Feeding problems
☐	☐	Hearing problems
☐	☐	Vision problems
☐	☐	Heart murmur

HOSPITAL, SURGERY, OTHER MAJOR ILLNESS OR INJURY

Date	Describe why hospitalized, nature of surgery, what illness

DRUG ALLERGIES OR REACTIONS ☐ **NONE**

Drug	Date of Reaction	What happened?

DRUGS CURRENTLY TAKEN ☐ **NONE**

(Once/month or more)

Drug	How Often	What for?

PREVENTION

Yes	No	
☐	☐	Child in car seat or seat belt at all times when riding in car
☐	☐	Poisons kept in a lock place
☐	☐	Pools, lakes, streams properly fenced or supervised
☐	☐	Knives and guns properly stored
☐	☐	Fireplace screened
☐	☐	Nutritious diet (your opinion)
☐	☐	Brush teeth daily

TUBERCULOSIS SKIN TEST

☐ Never had one
☐ Negative test (year _____, _____)
☐ Positive test (year _____, _____)

IMMUNIZATIONS

(Give dates of all in past on date/box)

DPT					
Tetanus booster					
Polio					
MMR					
Hib					
Varicella					
Prevnar					
Hepatitis A					
Hepatitis B					
Other					

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(addressograph stamp)

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MATERNAL HISTORY

Mother's age when this child born _____

Number of pregnancies prior to this child _____

Medical problems during this pregnancy:

(Illnesses, infections, anemia, blood pressure, etc.)

Medications taken during pregnancy: (list all):

Prenatal care was provided by:_____

Number of days mother in hospital after birth: _____

BIRTH HISTORY

Where born _____

Who delivered baby _____

Weight _____ Apgar scores (if known):
1 min _____ 5 min _____

Was baby born within 2 wks of expected day?
☐ Yes ☐ No ☐ Early ☐ Late

Hours of labor _____

Labor was ☐ Spontaneous
☐ Induced

Was medication given during labor? ☐ Yes ☐ No

Delivery was: ☐ Spontaneous vaginal delivery
☐ Forceps
☐ Cesarean section

Baby position: ☐ Head first
☐ Feet/bottom first

Problems or complications of delivery:

NEWBORN HISTORY (First few days of life)

Baby cried or breathed spontaneously within 1 or 2 min?
☐ Yes ☐ No

Was baby jaundiced (yellow)?
☐ Yes ☐ No

How many days in hospital? _____

Baby's problems or complications:

Was child breast fed?
☐ Yes How long?_____ ☐ No

DEVELOPMENTAL HISTORY

Give age at which child accomplished the following skills	
(Leave blank if not done currently)	(Age in months)
Roll stomach to back	_____
Laugh out loud	_____
Reach out for objects	_____
Sit without support	_____
Feed self crackers	_____
Say dada, mama in reference to right person	_____
Drink from a cup	_____
Walk well	_____
Toilet trained (daytime)	_____
Combine 2 words	_____
	(Age in years)
Give first and last name	_____
Dress self	_____

SOCIAL HISTORY

Give your brief assessment in 2-3 words of **your child's :**
Personality
Ways of comforting self
Expression of anger/frustration
Cooperation/obedience
Fears
Self-satisfaction/degree of happiness
Reaction to change
Relationship to other children
Number of close friends
School performance
Child's opinion of school
What do you like best about this child?
What concerns you most about this child?