Comfort Care PEDIATRICS

Child's History

Date_____

Patient Name_____

Birth History: Full Term_____# Weeks Early_____ Vaginal Delivery/C-Section, Birth Weight_____

Complications: _____

Medications Allergies: _____

Daily Medications: _____

Past Medical History: **Has your child had any of the following? If so, give brief description and dates**

Serious injuries or Accidents: _____ Concussions: _____

Stitches or broken bones: _____

Surgeries: _____
Hospitalizations: _____
Frequent Ear/Sinus Infections: _____
Frequent Tonsillitis or Strep: _____
Other Infectious Illnesses: _____
Animal Allergies: _____
Outdoor Allergies: _____
Indoor or Food Allergies: _____
Asthma or Bronchitis: _____
Pneumonia or Croup: _____
Heart Problems or Murmur: _____
Abdominal Pain or Reflux: _____
Constipation Requiring a Visit to the Doctor: _____
Bladder or Kidney Infections: _____
Other Urologic problems: _____
Bedwetting (after 5 yrs of age): _____
Eye Conditions: _____
Problem with Hearing: _____
Chronic or Recurrent Skin Problems (acne or eczema): _____
Anemia or Bleeding Problems: _____
Blood Transfusions: _____
Frequent Headaches: _____
Seizures/Neurological Disorder: _____
Developmental Delays or Learning Disabilities: _____
ADD or ADHD: _____
Mental Health Concerns: _____
Orthopedic Problems: _____
Diabetes: _____
Thyroid or other Endocrine problems: _____
If Female (date periods first started): _____
If Female any Problems with periods: _____
Use of Alcohol or Drugs: _____
Smoking: _____
Emotional Problems: _____
Other Significant Problems: _____

Family History:

Check the Box if **any family member** has the following:

Symptom or Disease	***Child's Mother***	***Child's Father***	***Child's Sibling***	***Grand Mother***	***Grand Father***	***Child's Uncle***	***Child's Aunt***	***Other***
Seasonal Allergies								
Eczema/Dry Skin								
Asthma/Lung Disease								
Heart Disease/Condition								
High Blood Pressure								
High Cholesterol								
Diabetes/Endocrine Prob.								
Cancer								
Anemia								
Bleeding Disorder								
Epilepsy/ Seizures								
Developmental Delays								
Mental Retardation								
Neurologic Disorder								
ADD/ADHD								
Liver Disease								
GI Disease								
Kidney Disease								
Bed Wetting after10yr old								
Hearing Impairment								
Vision Impairment								
Immune Problem Recurrent Infections								
Alcohol Abuse								
Drug Abuse								
Mental Illness								
Tuberculosis								
Other Pertinent Conditions								

Social History:

Who lives at home? _____

Does Child live with both Mother & Father? _____

Who has Custody of Child? _____

Visitation Arrangements? _____

Siblings? _____

Pets? _____

Smokers in Home? Yes or No (please circle)

Guns in Home? Yes or No (please circle)

Are guns locked up and kept separate from ammunition? Yes or No (please circle)