



Family Practice Associates

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Pediatric History and Physical Information

Parent(s) Name: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Birth Weight: _____

Past Medical History: (Circle any that apply)

- | | |
|--|---|
| 1. Recent respiratory infections
(cold, sore throat, ear infection) | 3. Congenital problems (heart defects, bladder
problems, foot problems, etc) |
| 2. Asthma | 4. Other: _____ |

Allergies: _____

Past Surgical History: _____

Family History: (Circle any if there is a significant family history.)

- | | |
|---------------------------------------|-------------------|
| 1. Heart Disease | 4. Seizures |
| 2. Hypertension (high blood pressure) | 5. Kidney trouble |
| 3. Allergies | 6. Cancer |

Immunizations: (Check if patient has received these)

Infant: 1. DPT___Polio	12-15 months: MMR ___	18 months: DPT___Polio	4yrs: DPT___Polio
2. DPT___Polio			
3. DPT___Polio			

History of Pregnancy:

- Age of mother at time of birth: _____ Was this the 1st, 2nd, 3rd, or more pregnancy? (circle one)
- Medical problems of mother during pregnancy: _____
- Was pregnancy: Full term / Early / Late ? (circle one)
- Any complications of labor or delivery? _____
- Did child breast feed? Yes___ No___



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Child's Name: _____ **Date of Birth** ___ / ___ / ___

Any problems during...

Infancy (0-2 years) _____

Childhood (Describe any changes in social behavior, school performance, overall health) _____

Adolescence (Describe any changes in social behavior, school performance, overall health) _____
