A C D Pediatric Group

PEDIATRICS HISTORY

PLACE ENCOUNTER LABEL OVER THIS BOX, OR FILL IN INFORMATION

ENCOUNTER #	PROVIDER #	DATE
LAST NAME	FIRST NAME	M.I.
PATIENT #	GROUP	HOME CENTER
DOB	SEX	PHONE #

FATHER'S NAME:	PHONE:	MOTHER'S NAME:	PHONE:
ADDRESS:	OCCUP.	ADDRESS:	OCCUP.
EMERGENCY CONTACT:		ADDRESS:	PHONE:
REFERRED BY:	PHONE:	GUARDIAN:	
ALLERGIES:			

D.O.B.	HEALTH	FAMILY HISTORY		
FATHER		MOTHER'S BLOOD TYPE	RH	
MOTHER		1) DIABETES	6) HEART DISEASE	11) MENTAL RETARD.
SIBLING M F		2) CANCER	7) BLOOD PRESSURE	12) S.I.D.S.
SIBLING M F		3) CONVULSIONS	8) LIPID (CHOL/TRIG)	13) MIGRAINE
SIBLING M F		4) ALLERGIES	9) KIDNEY	14) TB
SIBLING M F		5) ASTHMA	10) ANEMIA	

BIRTH & DEVELOPMENT

TYPE OF DELIVERY		TERM	LABOUR	APGAR
BIRTH WT.	LENGTH	DISCHARGE WT.	CONDITION	CIRCUMCISION Y N

MILESTONES	AGE
HELD HEAD UP	
SAT ALONE	
CREPT	
WALKED	
WORDS	
SENTENCES	
TEETH	
TOILET TRAINED	
SCHOOL GRADE	
BICYCLE	

FEEDING NUTRITION
BREASTS
FORMULA
VITAMINS
FLUORIDE

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

PAST HISTORY

GENERAL HEALTH

- ☐ CHICKEN POX ☐ PERTUSSIS ☐ RUBELLA
- ☐ MEASLES ☐ MUMPS ☐ SCARLET FEVER
- ☐ FREQ. COLDS / PHARYNGITIS ☐ EAR INFECTIONS
- ☐ TONSILLITIS ☐ SEIZURES ☐ INJURIES
- ☐ HOSPITALIZATIONS/SURGERIES
- ☐ SMOKING
- ☐ SUBSTANCE ABUSE
- ☐ ASTHMA
- ☐ RECURRENT INFECTIONS
- ☐ ANEMIA
- ☐ SPEECH AND HEARING PROBLEMS
- ☐ OTHER

PROVIDER'S NAME

PROVIDER'S SIGNATURE

DATE