BROOKS-SMITH LOWE INSTITUTE

PEDIATRIC HISTORY FORM

CHILD'S NAME:……..……………..…………… Age:..………Birthdate……………….….
Parents Name:…………………………………….……………… **Date filled out** ……………..……...
Address:……………………………………………………………………………………...
Telephone: Home……………….……. Work …………………………Cell………………..
Email address ………………………………………………………………..……………

(A) **BIRTH HISTORY**

1. Birth place…………………………………………………………………….……...
2. Was pregnancy normal……..…………………… Was delivery normal ..………………...
3. Was baby full term……………………..…. Birth weight…..………………………
4. Blood group………………Any nursery Problem?…………………………………

(B) **ANY PROBLEMS WITH**:

1. Sleeping?………. Snoring?……….. Bedwetting?………. Nightmares?……………
   Weight/Height………………… Constipation ?………….. Nail biting?……..………
2. Appetite: Poor?………… Normal?…………. Excessive?……………….
   Nursed or bottlefed?…………………….. Use special diets? …………………...
   Taking vitamins?……………………… What name?…………………………
3. Contagious Diseases (What age?)-
   Measles ………… Mumps…………… Rubella (German Measles)……….
   Chicken Pox ……………. Scarlet Fever ………….. Any other……………...
4. **Medications** (does your child take any now?) ……………………….…………….

(C) **HOSPITALIZATIONS**:

Medical …… Why………………………………………………………………..
Surgical …… Why ………………………………………………………….………

(D) **ALLERGIC REACTIONS**:

Drugs, Asthma, Hives, Hay fever , Food (specify)………………………

(E) **FAMILY HISTORY**

1. Father: Living?………….. Mother: Living?…………
2. Brothers: How Many?…… How Old?……Sisters: How Many?…… How Old?……

ANY FAMILY HISTORY OF:

Diabetes……….. Allergies……….. Convulsions(Seizures)…….. Heart Disease……
Cancer…………. High Blood Pressure……... Other?…………………………………..

(F) **SOCIAL HISTORY**

1. What kind of house (a) Board Y N (b) Concrete Y N
2. How many (a)Adults?……………… (b) Children?…….
3. Does any one drink alcohol? Y N
4. Does any one smoke (a) Cigarettes Y N (b) Marijuana Y N
5. Do you have an: (a) Outside toilet? Y N (b) Inside toilet? Y N
6. Do you use pipe borne water? Y N

(G) **GENERAL SURVEY**

1. Has your child had any unusual problems with the following
   Head……………………………………………………………………..…….
   Eyes…………………………………………………………………………….
   Ears/Nose/Throat……………………………………………………………
   Stomach/Chest/Heart/Lungs……………………………………………………...
   Kidneys/Bladder……………………………………………………………..…
   Bones/Muscles/Joints ………………………………………………………….
   Skin………………………………………………………………………….

(H) **YOUR CHILD'S LAST DOCTOR WAS**………………………………...…………...