Viridian MD Pediatric History Form Ages 1 to 8 Years

General Information

Patient's full name:

Patient's date of birth:

Nickname:

Patient's previous doctor:

(Optional) Race:

Ethnicity: ☐Hispanic ☐Non Hispanic

Current medications

Please include vitamins, supplements and herbs:

Allergies

☐ None

☐ Food:

☐ Seasonal:

☐ Other:

Pregnancy and Delivery

Where was patient born? (State and hospital):

Is the patient yours by:

☐ Birth ☐ Adoption

☐ Stepchild ☐ Foster child

☐ Other

Pregnancy:

Any medications taken during pregnancy:

☐ None ☐ Prenatal vitamins

☐ Other

Please indicate any complications:

☐ None ☐ Group B Strep positive

☐ Preterm labor ☐ Hepatitis B

☐ High blood pressure ☐ Herpes

☐ Gestational diabetes ☐ Preeclampsia/Toxemia

☐ Other

Delivery:

☐ Vaginal ☐ Caesarian Section ☐ Breech

Birth weight: Birth length:

Please indicate any complications:

☐ None ☐ Prolonged delivery

☐ Forceps ☐ Needed oxygen

☐ Jaundice ☐ Phototherapy

☐ Premature & how early?

☐ Admitted to NICU & why?

Immunizations

Please bring a copy of your immunization record to your first appointment, or send it by mail or fax with this form.

☐ Immunizations current

☐ Behind on immunizations & why:

☐ Not immunized & why:

Family Social History

Who lives at home with patient? (Include parents, siblings, grandparents, etc.)

Household #1

Name	Age	Relationship

Household #2

Name	Age	Relationship

If patient spends time in two households, describe custody arrangements (50/50, etc):

Parent #1 occupation:

Parent #1 employer:

Parent #2 occupation:

Parent #2 employer:

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Past Medical History

☐ Current or previous medical diagnoses:_____

_____

_____

☐ Hospitalizations & why? (Include age or date):___

_____

_____

☐ Surgeries & why? (Include age or date):_____

_____

_____

☐ Injuries, concussions, fractures, stitches, etc:_____

_____

Development:

Have you or a previous provider had concerns regarding your child's development (speech, gross motor, fine motor, etc)? ☐ Yes ☐ No

If Yes, please describe:_____

_____

_____

If Yes, has your child had any evaluations or services?

_____

_____

Nutrition:

☐ Eats a well-balanced diet ☐ Vegetarian

☐ Vegan ☐ Picky eating or nutritional concerns

Milk intake:_____ounces/day (8 oz = 1 cup)

Milk type:_____

Has your child had any dietary or feeding problems? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Sleep: Hours per night:_____

Naps if applicable: _____

Where does your child sleep?_____

Any sleep problems?_____

_____

Dental: Is the patient seeing a dentist? ☐ Yes ☐ No

How often?_____

Dental problems or concerns:_____

_____

School or Daycare:

Current school or daycare:_____

Grade level:_____

If daycare, how soften?_____

Any concerns about school performance?

☐ Yes ☐ No If yes, please explain:_____

_____

_____

Social/Emotional History:

Have you or a previous provider had concerns regarding your child's behavior/emotional needs?

☐ Yes ☐ No

If Yes, please describe:_____

_____

_____

If Yes, has your child had any evaluations or therapy?_____

_____

_____

Activities/Exposures/Habits:

☐ Physical Activity:_____

_____

☐ Other activities:_____

Number of hours per week of activities:_____

Number of hours per day of screen time (TV, computers, video games, etc.):_____

Any family members smoke (inside or outside)?

☐ Yes ☐ No

Firearms in the home? ☐ Yes ☐ No

If yes, are locked? ☐ Yes ☐ No

Review of All Systems: Please check any current or past medical problems your child has had.

General:

- ☐ Recurrent Fever
- ☐ Excessive sweating
- ☐ Chills
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Unexplained weight gain

Eyes:

- ☐ Wears glasses
- ☐ Wears contacts
- ☐ Lazy eye(s)
- ☐ Crossed eyes

Ears, Nose & Throat:

- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Allergies
- ☐ Frequent runny nose
- ☐ Snoring
- ☐ Frequent bloody nose
- ☐ Frequent sore throats or strep throat
- ☐ Problems with teeth and gums

Respiratory:

- ☐ Asthma
- ☐ Chronic cough
- ☐ RAD or wheezing
- ☐ Chest pain
- ☐ Recurrent croup
- ☐ EIB
- ☐ Shortness of breath with exercise

Cardiovascular:

- ☐ Heart murmur
- ☐ Heart defect
- ☐ Fainting
- ☐ Arrhythmia
- ☐ Poor endurance compared to peers

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Unexplained vomiting
- ☐ Blood in stools
- ☐ Frequent stomachaches
- ☐ Jaundice
- ☐ Soiling underwear

Genitourinary:

- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ UTI
- ☐ Urinary reflux

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Head injuries
- ☐ Concussions - If so, indicate the #_____

Neurological:

- ☐ Tension headaches
- ☐ Dizziness
- ☐ Migraine headaches
- ☐ Fainting
- ☐ Seizures
- ☐ Staring spells

Psychiatric, Emotional & Education:

- ☐ ADD/ADHD
- ☐ Developmental delays
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Aggression/Fighting
- ☐ Speech problems
- ☐ Sleep difficulty
- ☐ IEP
- ☐ Learning difficulty
- ☐ Substance abuse

Skin:

- ☐ Eczema
- ☐ Acne
- ☐ Unusual moles
- ☐ Rashes
- ☐ Hives
- ☐ Bruising

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Short stature
- ☐ Precocious puberty

Specific infections (Plus age or date of infection):

- ☐ Chicken pox_____
- ☐ Meningitis_____
- ☐ RSV_____
- ☐ Tuberculosis_____
- ☐ Whooping cough (Pertussis)_____

Any other concerns?_____

_____

_____

_____

_____

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Family History: Please indicate using the following key any family members who at any time in their lives have been diagnosed with any of these conditions. Please indicate if any family members have died from any of these conditions.

KEY-PLEASE USE THE FOLLOWING IDENTIFIERS FOR FILLING OUT THE FAMILY HISTORY

Mother = Mother of Patient	**Brother** = Brother of Patient	**Grandfather** = Patient's Grandfather	**Aunt** = Mother or Father's Sister	**Cousin** = Cousin of Patient
Father = Father of Patient	**Sister** = Sister of Patient	**Grandmother** = Patient's Grandmother	**Uncle** = Mother or Father's Brother	

Mother's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
Educational difficulties_____
GI disorders (Reflux, Colitis, Crohn's)_____
Hearing loss_____
Heart disease_____
Heart arrhythmia (Prolonged QT, SVT)_____
High blood pressure_____
High cholesterol_____
Hip dysplasia_____
Kidney disease_____
Lazy eye (Strabismus)_____
Melanoma_____
Mental illness_____
Migraine headaches_____
Obesity/Overweight_____
Renal reflux_____
Rheumatological disease_____
Scoliosis_____
Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____

Father's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
Educational difficulties_____
GI disorders (Reflux, Colitis, Crohn's)_____
Hearing loss_____
Heart disease_____
Heart arrhythmia (Prolonged QT, SVT)_____
High blood pressure_____
High cholesterol_____
Hip dysplasia_____
Kidney disease_____
Lazy eye (Strabismus)_____
Melanoma_____
Mental illness_____
Migraine headaches_____
Obesity/Overweight_____
Renal reflux_____
Rheumatological disease_____
Scoliosis_____
Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____