CENTRAL OHIO℠ PRIMARY CARE

Pediatric Comprehensive Patient History

☐ New Patient ☐ Established Patient Today's Date: _____

For Internal Use Only
☐ Indexed
☐ Entered

Parent(s) Name: _____

Child's Full Name: _____ Date of birth: _____ Sex ☐ M ☐ F

Child's Doctor: _____ Referred by: _____

Child's Medical History ☐ Unknown ☐ No Significant Medical History

Complete this section if child is less than 5 years old or if there was a significant/complicated pregnancy history

Pregnancy/Birth History: *Check all that apply*
☐ Mother's age at delivery _____
Month prenatal care began _____
Weeks of pregnancy _____
Birth Weight _____ ☐ C-Section ☐ Vaginal

Pregnancy Complications:
☐ Infections ☐ Diabetes ☐ Pre-eclampsia
☐ Multiple Gestations _____
☐ Other _____

Birth/Newborn Complications:
☐ Other _____
☐ Premature? – How early? _____
☐ NICU stay? – How long? _____

Medications: _____
☐ Infections _____

During pregnancy, the child's mother:
☐ Smoked - How much? _____
☐ Drank alcohol - How much? _____

Current Medications:

Allergies to Medicines:

Reaction:

This Child has been DIAGNOSED with:

☐ ADD/ADHD	Age:_____	
☐ Allergies/Hay fever	Age:_____	
☐ Anemia	Age:_____	
☐ Asthma	Age:_____	
☐ Autism	Age:_____	
☐ Bipolar Disorder	Age:_____	
☐ Blood Disorder/Sickle Cell	Age:_____	
☐ Broken Bones - Detail below		
_____	Age:_____	
_____	Age:_____	
☐ Cancer - Type: _____		
	Age:_____	
☐ Celiac Disease	Age:_____	
☐ Chicken Pox	Age:_____	
☐ Constipation	Age:_____	
☐ Depression	Age:_____	
☐ Developmental Delay	Age:_____	
☐ Diabetes	Age:_____	
☐ Frequent Ear Infections	Age:_____	
☐ Gastrointestinal disorder	Age:_____	
☐ Headaches/migraines	Age:_____	
☐ Learning Disability	Age:_____	
☐ Pneumonia	Age:_____	
☐ Scoliosis (curved spine)	Age:_____	
☐ Seizures/epilepsy	Age:_____	
☐ Skin Issues	Age:_____	
☐ Stomach Problems	Age:_____	
☐ UTI/Bladder Infections	Age:_____	
☐ Other _____		

Child's SURGERIES ☐ None

☐ Appendectomy	Age:_____	☐ Eye Surgery	Age:_____
☐ Adenoidectomy	Age:_____	☐ Hernia repair	Age:_____
☐ Ear Tubes	Age:_____	☐ Tonsillectomy	Age:_____
☐ Other _____	Age:_____	☐ Other _____	Age:_____

Child's Hospitalizations:
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____
Hospitalization: _____ Age: _____

Child's Family History: Please let us know about the CHILD's parents' health by checking the boxes that apply.

Mother ☐ Unknown ☐ Healthy ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness Type: _____
Other condition(s) _____

Father ☐ Unknown ☐ Healthy ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness Type: _____
Other condition(s) _____

Please check diagnosis and indicate family member:

	Sister	Brother	Grandparent	Aunts/Uncles
☐ ADD	☐	☐	☐	☐
☐ Allergies	☐	☐	☐	☐
☐ Asthma	☐	☐	☐	☐
☐ Autism	☐	☐	☐	☐
☐ Blood Disorder/Sickle Cell	☐	☐	☐	☐
☐ Celiac Disease	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐
☐ Heart disease before age 55	☐	☐	☐	☐
☐ High Cholesterol	☐	☐	☐	☐
☐ Seizures/epilepsy	☐	☐	☐	☐
☐ SIDS (crib death)	☐	☐	☐	☐
☐ Sudden Death before 50	☐	☐	☐	☐

Social/Environmental Child lives w/:
☐ Parent(s): ☐ Together ☐ Apart/Shared
☐ Mother
☐ Father
☐ Relative _____
☐ Other _____

Adopted ☐
Smokers live in home with child? ☐ Yes ☐ No
Child attends day care? ☐ Yes ☐ No
Pets in the home? ☐ Yes ☐ No
Well water? ☐ Yes ☐ No
Home built before 1960? ☐ Yes ☐ No

Other _____