Muddy Creek Pediatrics
Initial History

Name of Patient _____ Sex: ____ Male ____ Female DOB ___/___/___

Form Completed By _____ Relation to patient _____ Date ___/___/___

Family

Are mother and father □ married □ separated / divorced □ other ?
If separated/divorced, what is the patient's custody status?

If one or both parents are not living in the home, how often does

Child see that parent? _____

Are there siblings living away from home ? □ Yes □ No

If yes, give name, age and where they live: _____
_____

List all family members in the patient's home

Name	Relation	Birth Date	Health Problems
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

Current Medical History

Are immunizations up to date? □ Yes □ No

Is your child having any medical problems? □ Yes □ No

Do you consider your child to be in good health? □ Yes □ No

Current Medications:

Drug Allergies? □ Yes □ No

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:

	Yes	No	*Explain*
1. a serious medical problem?	□	□	_____
2. been hospitalized or had surgery?	□	□	_____
3. had a serious injury or accident?	□	□	_____
4. chickenpox? When? _____	□	□	_____
5. allergies, asthma, bronchitis, respiratory infections?	□	□	_____
6. repeated ear infections, tubes, difficulty with hearing?	□	□	_____
7. heart problems or a heart murmur?	□	□	_____
8. problems with eyes or vision?	□	□	_____
9. anemia, bleeding problems or blood transfusion?	□	□	_____
10. recurrent vomiting, recurrent diarrhea, blood in stools?	□	□	_____
11. abdominal pain, constipation requiring doctor visits?	□	□	_____
12. recurrent skin problems (acne, eczema, etc)?	□	□	_____
13. bladder or kidney infections, bed-wetting after 5 years?	□	□	_____
14. diabetes, thyroid or other endocrine problems?	□	□	_____
15. headaches, convulsions, other neurologic problems?	□	□	_____
16. If female, has she started her menstrual periods?	□	□	_____
If yes, is she having any problems?			_____

Name of Patient _____ **Date** _____

Development *Are you concerned about the patient's…*

1. physical development?
2. attention span or activity level?
3. learning ability?
4. mental or emotional development?

If in school, has the patient had…

1. behavioral problems
2. placement in a special or resource class?
3. tutoring outside of the classroom?
4. to repeat a grade?
5. educational or psychological testing?

Yes	No	
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____

Yes	No	
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ urinary infections ☐ excessive wt. gain ☐ excessive swelling ☐ toxemia ☐ venereal disease ☐ rubella ☐ none ☐ other

_____

Did the mother smoke, use alcohol or drugs during pregnancy? ☐ Yes ☐ No

Birth

Birth weight _____ Length _____ Apgar _____ Was baby born at: ☐ Early ☐ Late ☐ Term
If early, how many weeks gestation? _____ Was labor difficult or prolonged? ☐ Yes ☐ No

Was delivery complicated or difficult? _____

_____

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast _____ ☐ Formula _____

☐ slow weight gain ☐ colic ☐ jaundice ☐ recurring diarrhea ☐ recurring vomiting ☐ blood in stools ☐ multiple formula changes

☐ none ☐ other _____

_____

Family History

If a family member has or has any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling GF-Grandfather GM-Grandmother A-Aunt U-Uncle

1. ☐ _____ Anemia/Blood disorders
2. ☐ _____ Ear infections/tubes
3. ☐ _____ Epilepsy or convulsions
4. ☐ _____ Eye or visual problems
5. ☐ _____ Hereditary problems
6. ☐ _____ High cholesterol
7. ☐ _____ Drug/Alcohol abuse
8. ☐ _____ Mental Retardation
9. ☐ _____ Migraine headaches
10. ☐ _____ Diabetes before 50 yrs.
11. ☐ _____ Bladder/Kidney
12. ☐ _____ Respiratory infections
13. ☐ _____ Stomach/GI
14. ☐ _____ Tuberculosis
15. ☐ _____ Heart attack/stroke before 50
16. ☐ _____ Heart problems, other
17. ☐ _____ Immunity problems/HIB
18. ☐ _____ Learning prob./Attn. span
19. ☐ _____ Thyroid/other endocrine prob.
20. ☐ _____ Emotional/behavioral
21. ☐ _____ High blood pressure before 50
22. ☐ _____ Drug allergies
23. ☐ _____ Eczema
24. ☐ _____ Allergies
25. ☐ _____ Asthma
26. ☐ _____ Arthritis
27. ☐ _____ Deafness
28. ☐ _____ Cancer
29. ☐ _____ Birth defects
30. ☐ _____ Obesity
31. ☐ _____ Liver disease
32. ☐ _____ Mental Illness
33. ☐ _____ Other

Provider Comments: