PEDIATRIC BASELINE HISTORY FORM **www.familywellnesscntr.com**

NAME _____ **DOB** _____ **Today's Date** _____

Birth History: Birth Weight _____ □ Born at due date □ Early □ Late
C-Section Vaginal Birth *(circle one)*
Problems as a newborn or with pregnancy _____
Is child currently breastfeeding? YES NO

LOCAL PHARMACY:
Phone #:
MAIL ORDER Pharmacy:
Address:
City/ ST/Zip:
Phone #:
Member ID#:

MEDICATIONS (including OTC & herbs):
Name: Mg. / Dosage

If more medications, please write on back of this form.

ALLERGIES: Are you allergic to any of the following? ***(please circle all that apply)*** **NONE**
Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: _____
If yes, explain the associated allergic reaction: _____

PAST MEDICAL HISTORY

Has your child been diagnosed or had any of the following? ***(please circle): If yes, please explain below & include age of onset:***

AIDS / HIV Positive	**Yes No**	**Constipation**	**Yes No**	**Jaundice**	**Yes No**
Anaphylaxis	**Yes No**	**Control of Urine / Bed Wetting**	**Yes No**	**Kidney Stones**	**Yes No**
Anemia	**Yes No**	**Depression**	**Yes No**	**Leukemia**	**Yes No**
Anxiety	**Yes No**	**Diabetes**	**Yes No**	**Migraines**	**Yes No**
Asthma	**Yes No**	**Drug Addition**	**Yes No**	**Recent Weight Loss**	**Yes No**
BiPolar	**Yes No**	**Epilepsy or Seizures**	**Yes No**	**Rheumatic Fever**	**Yes No**
Blood Transfusion	**Yes No**	**Eyes, Vision problems**	**Yes No**	**Scarlet Fever**	**Yes No**
Cancer	**Yes No**	**Hay Fever / Allergies**	**Yes No**	**Skin / Mole Changes**	**Yes No**
Congenital Heart Disease	**Yes No**	**Headaches**	**Yes No**	**Spina Bifida**	**Yes No**
Chicken Pox	**Yes No**	**Heart Murmur**	**Yes No**	**Strep Throat, chronic**	**Yes No**
Chronic Ear Infections	**Yes No**	**Irregular Heartbeat**	**Yes No**		

Any other serious illness not listed above? Yes No If yes, please explain:_____
_____
_____

Has your child ever been hospitalized or had a major operation? YES NO If yes, please explain_____
_____
_____

SOCIAL HISTORY:

Family / Household member(s) (any person who lives in your household):

Name	Birth Yr	Relationship	Name	Birth Yr	Relationship

Is your child on a special diet? YES NO If yes, please explain_____
Are immunizations up to date? _____ ***Please bring a copy of any immunization records.***
Are there guns in the house? ***(Please circle)*** **YES NO If yes, are they locked up? _____**
Does anyone smoke cigarettes or other tobacco products around your child? ***(Please circle)*** **YES NO**
Does your child drink caffeinated beverages daily? ***(Please circle)*** **YES NO If yes, how often? _____**
Does your child wear a seat belt when in the car? YES NO Does your child wear a helmet when riding a bike? YES NO
Do you have pets? YES NO If yes, what type(s)? _____
Circle child's highest grade completed: K 1 2 3 4 5 6 7 8 9 10 11 12 Home Schooled: YES NO

FAMILY HISTORY:

Has anyone in your child's immediate family had: (parents, siblings, or grandparents only)

History of:	Yes	No	If yes, family relationship(s):	Type:	Age of onset:
Alcoholism					
Seasonal Allergies					
Diabetes					
Tuberculosis					
Heart Disease					
Stroke					
High Cholesterol					
Depression / Anxiety / Bipolar					
Suicide					
Cancer					
Thyroid issues					
Major medical problems					
Sudden Deaths					

REVIEW OF SYSTEMS:

Do you now have problems with: (***Mark problems with an "X")*** ***If none of the following are complaints, please circle:*** NONE

	Present		Present		Present
1. GENERAL:		**5. CARDIOVASCULAR:**		**8. MUSCULOSKELETAL:**	
* **Weight loss, unplanned**		* **Chest Pain**		* **Joint Pain**	
* **Fatigue**		* **Irregular Heart Beat**		* **Joint Swelling**	
* **Memory Loss**		* **Elevated Blood Pressure**		* **Jaw Pain**	
		* **Heart Disease**		**9. NEUROLOGICAL:**	
2. HEENT:		* **Shortness of Breath**		* **Blackouts**	
* **Headache**		* **Swelling of Limbs**		* **Dizziness**	
* **Visual Loss**		**6. GASTROINTESTINAL:**		* **Seizures**	
* **Decreased Hearing**		* **Bloody Stool**		* **Stroke**	
* **Sinus Pain**		* **Constipation**			
* **Hoarseness**		* **Diarrhea**		**10. PSYCHIATRIC:**	
* **Sore Throat**		* **Heart Burn**		* **Anxiety**	
* **Trouble Swallowing**		* **Jaundice**		* **Depression**	
		* **Kidney Stones**		* **Sleep Issues**	
		* **Nausea**		**11. ENDOCRINOLOGY:**	
3. RESPIRATORY:		* **Vomiting**		* **Diabetes**	
* **Cough**				* **Excessive Thirst**	
* **Wheezing**		**7. FEMALE / Genitourinary:**		* **Excessive Urination**	
		* **Abnormal PAP smear**			
4. BREAST:		* **Urinary Complaints**			
* **Breast Mass**		* **Blood in Urine**		**12. HEMATOLOGY:**	
* **Breast Pain**		* **Menstrual Irregularities**		* **Anemia**	
* **Skin Changes**				* **Bleeding Issues**	

FOR TEENS only:

For girls, Date of Last Menstrual Period: _____ Are periods regular? YES NO Age when first started: _____

Do you smoke cigarettes or use tobacco products? YES NO If yes, age when started: _____ How many per day?_____

Do you use marijuana, cocaine, or other non-prescribed narcotics? YES NO If yes, what type: _____

How many beers or alcoholic beverages do you drink weekly? _____