CHILDREN'S CLINIC OF RACELAND

110 Acadia Drive, Raceland, LA 70394 ■ Phone: (985)537-8687 ■ Fax: (985)537-8976

PEDIATRIC HISTORY

Patient's Name: First_____Middle_____ Last_____
Date of Birth: _____ Age: _____ Sex: ☐Female ☐Male
Person completing this form_____ Date Completed: _____

BIRTH HISTORY

Birth Weight _____ Discharge Weight_____
Type of delivery ☐Vaginal ☐ Cesarean Gestational Age: _____weeks
Prenatal or neonatal complications: ☐Yes ☐ No Explain: _____
NICU stay? ☐Yes ☐No Explain: _____
Hospital Name: _____ Initial feeding: ☐ Formula ☐ Breast Milk

PRENATAL HISTORY

Prenatal vitamins ☐ Yes ☐ No
Use tobacco ☐ Yes ☐ No Drink alcohol ☐Yes ☐ No
Use drugs or medications ☐ Yes ☐ No What medications? _____

PAST MEDICAL HISTORY

Acne	☐Yes	☐No	Headaches	☐Yes	☐No
ADD	☐Yes	☐No	Heart murmur	☐Yes	☐No
Allergic Rhinitis	☐Yes	☐No	Heart Problem	☐Yes	☐No
Asthma	☐Yes	☐No	Heartburn/Reflux	☐Yes	☐No
Constipation	☐Yes	☐No	Pneumonia	☐Yes	☐No
Croup	☐Yes	☐No	Seizure	☐Yes	☐No
Developmental delay	☐Yes	☐No	Speech delay	☐Yes	☐No
Diabetes	☐Yes	☐No	Sinus infections	☐Yes	☐No
Ear infections	☐Yes	☐No	Thyroid disease	☐Yes	☐No
Eczema	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Food Allergies	☐Yes	☐No	UT	☐Yes	☐No

Other MedicalHistory_____

Hospitalizations: _____

Surgical History: _____

Reaction to Anesthesia: _____

FAMILY HISTORY

Enter Relation to patient:

Father	MGP - Maternal grandparent	Paternal aunt/uncle
Mother	PGP - Paternal grandparent	Maternal cousin
Sibling	Maternal aunt/uncle	Paternal cousin

	Relation to patient		Relation to patient
Allergies	_____	HIV/AIDS	_____
Asthma	_____	Liver disease	_____
Alcohol abuse	_____	Lung disease	_____
Bleeding disorder	_____	Metabolic disorder	_____
Cancer	_____	Mental Illness/Depression	_____
Developmental disability	_____	Renal disease/Kidney stones	_____
Diabetes	_____	Seizure disorder	_____
Drug abuse	_____	Stroke	_____
Genetic disorder	_____	Thyroid disease	_____
GI disorder	_____	Tuberculosis	_____
Heart disease	_____	Tobacco use	_____
Hypertension	_____		

Other Family History _____

SOCIAL HISTORY

Please list all those living in the child's home

Name	Relationship to patient	Birth Date	Health Problems

Birth parents: ☐Married? ☐Divorced? ☐Mother deceased? ☐Father deceased?

What is the child's living situation?

☐Lives with both biological parents ☐Joint Custody

☐Lives with adoptive parents

☐Lives with Grandparents ☐Single custody

☐Lives with foster family

Does the patient attend Day Care (or other settings with multiple young children)? ☐Yes ☐No

Does the patient attend school/home school? ☐Yes ☐No Name of school_____

Does anyone in the household smoke? ☐Yes ☐No Who smokes? _____

Is the house that the patient live in more than 30 years old? ☐ Yes ☐ No