# Metrolina Medical Associates
## Initial Visit History—Pediatric

**Patient's Name: _____ DOB: _____ Date: _____**

Mother's Name: _____ Phone Number: _____ Age: _____

Father's Name: _____ Phone Number: _____ Age: _____

**Current Medical History:** Is your child having any medical problems? □ Yes □ No

_____

_____

**Maternal and Newborn History:**

*Pregnancy (check problem areas)*

□ Excessive wt. gain
□ Excessive swelling
□ Toxemia
□ Urinary Tract Infections
□ Rubella (3 day measles)
□ Venereal Disease

*Birth*

□ Vaginal
□ Caesarean Section
□ Full Term
□ Premature

Baby's Birth Weight _____

Was delivery difficult or complicated? □ Yes (please explain) □ No

_____

Did baby have any trouble while in the hospital (breathing, jaundice, infections etc.)? □ Yes (please explain) □ No

_____

*Newborn (check problem areas)*

□ Feeding problems
□ Colic
□ Recurrent vomiting
□ Recurrent diarrhea
□ Blood in stools
□ Slow weight gain
□ Jaundice
□ Multiple formula changes
□ Other (please explain) _____

*Newborn feeding*

□ Breastfed
For how long? _____
□ Formula
Brand _____

| **Immunizations** | Date | Date | Date | Date | Date | Date |
|---|---|---|---|---|---|---|
| HepB | | | | | | |
| Rotavirus | | | | | | |
| DTaP | | | | | | |
| Hib | | | | | | |
| Pneumo | | | | | | |
| IPV | | | | | | |
| MMR | | | | | | |
| Varicella | | | | | | |
| HepA | | | | | | |
| MCV4 | | | | | | |
| HPV | | | | | | |

**Past Medical History:**

Where has child gone for check-ups until now? _____

Date of last check-up _____ Date of last dental checkup_____

**Please continue on back**

*Please check all that apply*

□ Allergies (please list) _____

□ Reactions to immunizations (which ones and describe reaction) _____

□ Hospitalizations since birth (please list reason and age) _____

□ Serious injuries (please describe) _____

□ Current medications (please list) _____
_____

**Family Medical History:**

*Check if patient (P) or a member of the patient's family {father (F), mother (M), sibling(S) or grandparent (G)} have had the following illnesses or problems. List the appropriate initial after each.*

□ Allergies_____
□ Anemia _____
□ Asthma _____
□ Diabetes _____
□ Drug Allergies _____
□ Eczema _____
□ Frequent respiratory infections_____
□ High blood pressure_____
□ Heart attack/stroke before age 55 _____
□ Tuberculosis _____
□ Emotional or behavior problems_____
□ Chronic cough _____
□ Ear tubes _____
□ Stomach problems _____
□ Growth problems _____
□ Seizures _____
□ Cholesterol problems_____
□ Cancer _____
□ Alcohol or drug use_____
□ Mother used alcohol or recreational drugs during pregnancy_____
□ Other (please list) _____

List name, age, gender and general health of patient's siblings____

Are this child's parents in good health? □ Yes □ No (explain) _____

**Development and Behavior:**

*Please answer the following*

At what age did this child sit alone? _____

At what age did this child walk alone? _____

Did he/she say words by 18 months old? _____

What grade (or daycare) does he/she attend? _____

Has child had any trouble at school? _____

Does he/she get along with peers? _____

**Safety/Environment:**

*Please answer the following*

Does child live in a □ private home □ apartment □ mobile home □ other

Do you know the hottest temperature setting of the water in your pipes? □ Yes □ No

Is there a working smoke alarm on each floor of your home? □ Yes □ No

Does this child always use a child safety seat, booster seat, or seat belt when riding in a vehicle? □ Yes □ No

Are there any smokers living with this child? □ Yes □ No

Are there any guns in the home? □ Yes □ No

Are there any problems with the condition of the child's home (peeling paint, bad plumbing/wiring, pests etc)? □ Yes □ No

Does this child always wear a helmet when riding a bike, roller-blading or skate boarding? □ Yes □No

**Additional Comments:**_____
_____