Patient Name:_____Date of Birth:_____

PEDIATRIC ASSOCIATES, P.A.
Pensacola * Pace * Perdido
PRE-SCHOOL INITIAL HEALTH HISTORY

Birthplace (City & Hospital):_____Birth Weight:_____
Vaginal Delivery? Yes / No C-Section? Yes / No
Did infant pass all hospital screening tests? Yes / No Failed: _____
Did mother have any problems during pregnancy? Yes / No If yes, describe: _____
_____
Describe any problems encountered during the newborn period: _____
_____
Describe any early digestive or feeding problems: _____
_____
Describe any accidents requiring a doctor's care: _____
_____
Hospitalizations? Describe giving name of hospital, date, reason: _____
_____
Surgeries or stitches? Please list when and location: _____
_____
Medication currently in use? Please give name, amount and dose interval: _____
_____
Allergies? (Substance/Reaction) Describe: _____

Who lives in your home? _____
Do you have pets? Yes / No
Does anyone smoke inside? Outside? Please circle, or circle "No"
Development: Is your infant/child **behind – the same as – ahead** of other children of similar age in regard to rolling over, sitting up alone, crawling, standing, walking or talking? Any observed delay? Yes / No _____
FAMILY TRAITS : Please circle any of the following conditions shared by a **blood relative** of this child:

Any Brain Disorder	Convulsions/Seizures	School Learning difficulty	Asthma
Attention Deficit Disorder	Cystic Fibrosis	Heart Defect since Birth	Eczema
High Blood Pressure (< age 50)	High Cholesterol	Irritable Bowel Syndrome	Suicide
Stomach/Intestinal Ulcer	Ulcerative Colitis	Thyroid Disorder/Goiter	
Diabetes requiring Insulin	Polycystic Kidney Disease		
Kidney Stones	Anemia (low blood)	Sickle Cell	
Hemoglobin C	Hemophilia (free bleeder)		
Thalassemia	Depression	Violent Behavior	
Drinking Problem	Bipolar disorder	Schizophrenia	

Any long term condition requiring ongoing medical care?_____
or death prior to age 40?