BLUE FISH

PEDIATRICS

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Patient Name: _____ DOB: _____ Completed by: _____ Relation: _____

PREGNANCY & BIRTH

Mother's age at pregnancy?

Any illnesses during pregnancy? ☐ YES ☐ NO

Medication during pregnancy? ☐ YES ☐ NO

(exclude vitamins & iron)

☐ Smoking ☐ Alcohol ☐ Street drugs – during pregnancy?

At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)

Type of delivery? Birth Weight: Breech?:

Complications? ☐ YES ☐ NO Apgar:

Problems with baby at birth? Breathing: ☐ YES ☐ NO Jaundice: ☐ YES ☐ NO

Other:

Pass Hearing Screen? ☐ YES ☐ NO Mother's Blood Type:

Were you ever told baby was breech in the third (3rd) trimester? ☐ YES ☐ NO

PAST MEDICAL HISTORY

Allergic reactions? Medicine: ☐ YES ☐ NO

Food: ☐ YES ☐ NO Animals: ☐ YES ☐ NO Insect Bites: ☐ YES ☐ NO

Medications taken on a regular basis? (exclude vitamins)

Immunizations – up to date? ☐ YES ☐ NO Do you have records? ☐ YES ☐ NO

Hospitalizations – (when-where-why?)

Surgeries (when-where?)

	YES	NO		YES	NO		YES	NO
Red Measles	☐	☐	Mumps	☐	☐	German Measles (3 day)	☐	☐
Chicken Pox	☐	☐	Whooping Cough	☐	☐	Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐	Ear Infections	☐	☐	Strep Throat	☐	☐
Asthma/Wheezing	☐	☐	Eczema/Hives	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐	Problems with hearing	☐	☐
Bleeding Tendency	☐	☐	Urinary Infections	☐	☐	Problems with vision	☐	☐
Blood Transfusions	☐	☐	Joint Problems	☐	☐	Other	☐	☐

FEEDING & NUTRITION

Food Allergies

Appetite usually good? ☐ YES ☐ NO

Colic or feeding problems during the first 3 months? ☐ YES ☐ NO

Breast fed? ☐ YES ☐ NO Number of months?

Formula? ☐ YES ☐ NO Current brand?

Vitamins? ☐ YES ☐ NO Brand? Flouride? ☐ YES ☐ NO

FAMILY PROFILE

Parents ☐ Married ☐ Separated ☐ Divorced

Father's Age? Highest school grade? Health?

Mother's Age? Highest school grade? Health?

(List child's brothers, sisters, and their ages)

FAMILY MEDICAL HISTORY

Anemia/Blood Dis

Asthma

Mental Retardation

Drug Problem

Alcoholism

Cancer

Aids

Cystic Fibrosis

Musc. Dystrophy

Tuberculosis

Arthritis

Epilepsy / Seizures

Heart Disease

High Blood Pressure

Cholesterol Problem

Migraine

Sudden Infant Death

Birth Defects

Early Deafness

Diabetes

DEVELOPMENT & BEHAVIOR

Age at which child:

Sat alone: Walked: Bicycled:

Toilet trained: Used sentences:

Development compared to other children?

Grade in school:

Problems in school? ☐ YES ☐ NO

Learning problems? ☐ YES ☐ NO

Getting along with other children? ☐ YES ☐ NO

Behavior problems? ☐ YES ☐ NO

Bad Habits? ☐ YES ☐ NO

Bedwetting? ☐ YES ☐ NO

Nail biting? ☐ YES ☐ NO

Sleeping? ☐ YES ☐ NO

Hobbies / sports?

Use of street or illegal drugs? ☐ YES ☐ NO

SYNOPSIS