ELFHP (13 years and Under) **Pediatric History Form** Date Completed: ___________

Please complete ALL pages, as it will become part of your permanent record. Male Female

NAME: ________________________________ DOB: ___________ Age: ___________

Parent/Guardian Information

Parent/Guardian Name:	
Relationship:	
Address:	
Parents' Marital Status:	S / M / D/ Not Married but living together
Is patient adopted/ foster child?	Y N
Who is the primary caregiver?	

Medications

Medications/Vitamins/OTC	Dose	Times/Day

Allergies

Medication/Food/Allergies	Reaction/Side Effect

Diet	
How is the child fed?	-
Breast Fed?	Y N
Formula?	Y N
Brand:	
# of ounces per feeding?	
Time between feedings?	
Milk/Soy Milk?	
# of ounces per day?	
Baby Food?	Y N
Cereal?	Y N
Vegetables?	Y N
Fruit	Y N
Meat	Y N

History

Prenatal History	-
Did prenatal care begin in 1st trimester?	Y N
Mother's age at delivery?	
How many total pregnancies has the mother had?	
How many live deliveries (including patient) has the mother had?	
Were there any complications during the pregnancy?	Y N
Did the mother use any of the following during pregnancy:	Y N
Tobacco	Y N
Alcohol?	Y N
Prescription drugs?	Y N
OTC medications?	Y N
Recreational drugs?	Y N
Supplements?	Y N
Birth History	-
Was the child:	-
Premature	Y N
Full term	Y N
C-section	Y N
At what hospital was the child born?	
What was the child's birth weight?	lb oz
Were there any complication during delivery? Yes, ________________	Y N
Did the child experience any of the following at or shortly after birth:	-
Jaundice	Y N
Rash	Y N
Seizures	Y N
Birth Injuries	Y N
Breathing problems	Y N
Did the child need to spend any time in the NICU after delivery?	Y N
Personal / Family History	
Does the child nap during the day?	Y N
Has he/she ever been hospitalized?	Y N
If yes explain:	
Please list any surgeries:	
Please list any chronic medical conditions of the mother and/or father:	
Please list any concerns you would like addressed:	

Sleep	-
How many hours of sleep does the child get each night?	
Does the child nap during the day?	Y N
If yes, how many hours?	
In what position does he/she sleep?	
Back?	Y N
Stomach?	Y N
Side?	Y N
Environment	-
Does anyone in the household smoke?	Y N
Are there any animals in the home?	Y N
Cat(s)	
Dog(s)	
Other:	
Does the child attend daycare?	Y N
Are there any guns/weapons in the home?	Y N
Number of people living in the home?	Y N

ELFHP

Patient History Form

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Male Female

NAME: ______________________________ DOB: ___________ Age: ___________

Condition	*Mother*	*Father*	*Sister*	*Brother*	*Other*
Age of Death/Cause					
ADD/ADHD					
Alcoholism					
Alzheimer's					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Cancer-type:___________					
COPD					
Coronary Artery Disease					
Depression					
Diabetes					
Drug Abuse					
Glaucoma					
Heart Attack					
Heart Disease-type:_____					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Migraines					
Obesity					
Osteoporosis					
Prostate Problems					
Seizures					
Stroke					
Thyroid Disorder					
Other					

ELFHP

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Male Female

NAME: ______________________________ DOB: ___________ Age: ___________

ENT
- Ear tubes
- Ear Infections-Frequent
- Hearing Loss
- Ear Pain
- Strep Throat
- Sore Throat
- Snoring
- OTHER

Cardiovascular
- Heart Murmur
- Abnormal Heart Rhythm
- Congenital Defect
- Blue Hand/Feet
- Chest Pain
- Passing Out
- OTHER

Pulmonary
- Asthma
- Croup
- RSV
- Cough
- Shortness of Breath
- Cystic Fibrosis
- Wheezing
- Pulmonary Embolism
- OTHER

Gastrointestinal
- Constipation
- Stoll-Holding Behavior
- Incontinence (Stool)
- Diarrhea
- Vomiting
- Abdominal Pain
- Reflux/Spitting Up
- Trouble Feeding
- Jaundice
- Hernia
- Umbilical Cord Concerns
- OTHER

Renal/Genitourinary
- Increased Urination
- Bedwetting
- Frequent UTIs
- OTHER
- Male: -
- Circumcision
- Undescended Testicles
- Female: -
- Vaginal Discharge
- Vaginal Irritation

Musculoskeletal
- Joint/Muscle Pain
- 'Bow-Legged'
- 'Knock-Kneed'
- Abnormal Gail
- Abnormal Skull Shape
- OTHER

Eyes
- Eyes Crossed
- Drooping Eyelids
- Vision Problems
- Glasses
- Eye Pain
- Watery Eyes
- OTHER

Endocrine
- Abnormal Weight Gain
- Abnormal Weight Loss
- Fatigue
- Diabetes
- Increased Thirst
- Unusual Growth
- OTHER

Neurological/Genetic
- Developmental Delay
- Autism
- Speech Delay
- Cerebral Palsy
- Down Syndrome
- Headaches
- Seizure Disorder
- OTHER

Hematologic
- Anemia
- OTHER

Allergies/Immunology
- Allergies
- Immunofeficiency
- OTHER

Dermatology
- Rash
- Chicken pox
- Diaper Rash
- Sore(s)
- Unusual Mole
- Birth Mark
- Hives
- Eczema
- OTHER

Hematologic
- Easy Bleeding
- Easy Bruising
- OTHER

Pyschology
- ADD/ADHD
- Behavior Problems
- OTHER