West Alabama Pediatrics
Patient History Intake Sheet

Today's Date:_____

Name:_____ Date of Birth:_____ Current Age:_____

Name of Person Completing Form:_____

Child's Birth History:

Birth Weight:_____ Delivery Hospital:_____

Doctor:_____

Length of Pregnancy:_____ weeks Early (<38 wks) Term(38-42 wks) Late (>42 wks)

Type of Delivery: □ Vaginal □ C-Section Reason:_____

Complications of Pregnancy, Labor, or Delivery: □ No □ Yes, List _____

Baby went to: □ Well Baby Nursery □NICU … Length of Stay_____

APGAR Scores: 1 minute_____ 5 minutes_____

Problems in Nursery? □ No □ Yes, List_____

Mother's Age at Delivery:_____

Previous Pregnancies:

Full Term:_____

Premature:_____

Miscarriages/Abortions:_____

Child's Family History:

Relationship	Age	Medical Problems		Describe
		No	Yes	
Mother	_____	□	□	_____
Father	_____	□	□	_____
Sister(s)	_____	□	□	_____
Brother(s)	_____	□	□	_____

Child's Past Medical History:

	No	Yes	Reason	Date/Hospital/Doctor
Hospitalizations:	□	□	_____	_____
			_____	_____
Surgeries:	□	□	_____	_____
			_____	_____

Allergies:			Type	Describe Reaction
Medication	□	□	_____	_____
			_____	_____
Food	□	□	_____	_____
			_____	_____
Other	□	□	_____	_____

Has Your Child Ever Had:

	No	Yes		No	Yes		No	Yes
Asthma/Wheezing	□	□	Ear Infections	□	□	Seizures	□	□
Breathing Problems	□	□	Fractures/Injuries	□	□	Skin Problems	□	□
Bronchiolitis	□	□	Heart Problems/Murmur	□	□	Slow Development	□	□
Bronchitis	□	□	Joint Problems/Arthritis	□	□	Tonsillitis	□	□
Chicken Pox	□	□	Kidney Problems/Infections	□	□	Vision/Eye Problem	□	□
Difficulty Talking	□	□	Pneumonia	□	□	Other:_____		

Has a Relative of Your Child Ever Had:

(indicate child's: M-mother, F-father, B-brother, S-sister, MGM-maternal grandmother, MGF-maternal grandfather, PGM-paternal grandmother, PGF-paternal grandfather. Also include maternal or paternal aunts, uncles, or cousins.)

	No	Yes	Relationship		No	Yes	Relationship
ADHD	□	□	_____	Epilepsy	□	□	_____
Alcohol Abuse	□	□	_____	Family History of Allergies	□	□	_____
Arthritis	□	□	_____	Genetic Defects	□	□	_____
Asperger's Disorder	□	□	_____	Hearing Disorder	□	□	_____
Asthma	□	□	_____	Kidney Disease	□	□	_____
Autism	□	□	_____	MI/Heart Attack	□	□	_____
Blood Disorder	□	□	_____	Mental Retardation	□	□	_____
Cancer	□	□	_____	Muscular Dystrophy	□	□	_____
Celiac Disease	□	□	_____	Seizures	□	□	_____
Cystic Fibrosis	□	□	_____	Sickle Cell Trait	□	□	_____
Diabetes	□	□	_____	Skin Disease	□	□	_____
Digestive System Disorder	□	□	_____	Substance Abuse	□	□	_____
Down's Syndrome	□	□	_____	Thyroid Disease	□	□	_____
Eczema	□	□	_____	Tuberculosis	□	□	_____
Elevated Cholesterol	□	□	_____	Vision Disorder	□	□	_____

Other:_____

Child's Social History:

City or Area Where Child Lives:_____

Type of Home: □ House □ Mobile Home □ Apartment

City Water? □ Yes □ No Well Water? □ Yes □ No

Do you have access to the Internet? □ Yes □ No

Child Lives With: □ Mom & Dad □ Mom Only □ Dad Only □Other:_____

Parents are: □ Married □ Divorced □Single

Number of People in Household:_____ Relation to Child:_____

Father's Occupation:_____ Mother's Occupation:_____

Do Household Members Smoke? □ Yes □ No

Pets? □ Yes □ No Type:_____ Inside the Home? □ Yes □ No