Family Practice Associates

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Ph (501) 778-0934
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Pediatric History and Physical Information

Parent(s) Name: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Birth Weight: _____

Past Medical History: (Circle any that apply)

1. Recent respiratory infections (cold, sore throat, ear infection)
2. Asthma
3. Congenital problems (heart defects, bladder problems, foot problems, etc)
4. Other: _____

Medications (Currently Taking)

Name	**Amount**	**Taken? (i.e. one twice a day)**
1.		
2.		
3.		

Please write on back if additional space is needed.

Allergies: _____

_____

Past Surgical History: _____

_____

Family History: (Circle any if there is a significant family history.)

1. Heart Disease
2. Hypertension (high blood pressure)
3. Allergies
4. Seizures
5. Kidney trouble
6. Cancer

Immunizations: (Check if patient has received these)

Infant: 1. DPT___Polio 2. DPT___Polio 3. DPT___Polio	**12-15 months:** MMR ___	**18 months:** DPT____Polio	**4yrs:** DPT___Polio

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Child's Name: _____ Date of Birth___ / ___ / ____

History of Pregnancy:

1. Age of mother at time of birth: _____ Was this the 1st, 2nd, 3rd, or more pregnancy? (circle one)

2. Medical problems of mother during pregnancy: _____

_____

3. Was pregnancy: Full term / Early / Late ? (circle one)

4. Any complications of labor or delivery? _____

_____

5. Did child breast feed? Yes___ No___

Any problems during…

Infancy (0-2 years) _____

_____

_____

_____

Childhood (Describe any changes in social behavior, school performance, overall health) _____

_____

_____

_____

Adolescence (Describe any changes in social behavior, school performance, overall health) _____

_____

_____

_____