YELLOW SPRINGS PRIMARY CARE
888 DAYTON STREET, SUITE 106 YELLOW SPRINGS, OH 45387
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PEDIATRIC HISTORY & REVIEW OF SYMPTOMS

Please fill out this questionnaire concerning your child's information. All information will be kept confidential in your child's medical records and will not be released without your permission.

Last Name: _____

First Name _____ MI _____

Date of Birth: _____/_____/_____

Mother's Age:_____ Occupation:_____

Father's Age: _____ Occupation:_____

How many? Brother: _____ Sister: _____

Are parents: Married Divorced Separated Single Cohabitating

If parents are not together, is other parent involved?

☐ **YES** ☐ **NO**

Who lives at home with the patient?

_____

Does someone other than parents have legal custody?

☐ **YES** ☐ **NO**

Name: _____

(if yes, a copy of legal documentation must be provided)

MEDICAL HISTORY

Previous doctor:_____

Date of last check-up:_____

Circle any of the following illnesses your child has/had

UTIs kidney problems birth defect vision loss

asthma/wheezing hearing loss seizures

frequent ear infections diabetes heart murmur

stroke high blood pressure hemophilia tuberculosis

behavior disorder mental illness ADD/ADHD

cystic fibrosis cerebral palsy sickle-cell

muscular dystrophy physical handicap

cancer: _____ (type)

Has your child ever had any of the following:

- Allergic reactions to food or medicine?
  ☐ **YES** ☐ **NO**
  If YES, describe:
  _____
  _____
  _____

- Hospitalizations? ☐ **YES** ☐ **NO**
  If YES, describe:
  _____
  _____
- Surgery? ☐ **YES** ☐ **NO**
  If YES, describe _____
  _____
- Dental Visit? ☐ **YES** ☐ **NO**
  If YES, date of last visit: _____
- Medications? ☐ **YES** ☐ **NO**
  If YES, please list:
  _____
  _____
  _____
  _____
  _____
- Immunizations:
  - Is you child up to date on their immunizations? ☐ **YES** ☐ **NO**

If Yes, please provide shot record.

YSPC PEDIATRIC HISTORY & REVIEW OF SYMPTOMS

Last Name: _____ First Name _____

Date of Birth: _____/_____/_____

BIRTH HISTORY

Any problems with the pregnancy? ☐ **YES** ☐ **NO**

If YES, describe _____

_____

Was Mother on medications while pregnant?

☐ **YES** ☐ **NO**

If YES, describe _____

_____

Cigarettes/alcohol/drugs used while pregnant?

☐ **YES** ☐ **NO**

If YES, describe _____

_____

Was your baby born: On Time Late Early

- If late or early, how many weeks? _____
- Was baby delivered: Vaginal C-section

Any complications with the baby? ☐ **YES** ☐ **NO**

If YES, please explain:

_____

_____

_____

Baby's birth weight: _____lbs _____oz

DEVELOPMENTAL OR SCHOOL CONCERNS

Circle any developmental delays that your child has had:

Delay in development?

sitting walking talking

School difficulties?

behavior learning attention

Relationship concerns?

friends family school/teachers

Is your child involved in any special needs programs (i.e speech therapy, physical therapy)?

☐ **YES** ☐ **NO**

If YES, describe _____

_____

_____

FAMILY HISTORY

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:

allergies high cholesterol thyroid eczema

seizures high blood pressure heart disease

diabetes bleeding disorder tuberculosis

asthma mental retardation mental illness

sudden death blood clot sickle-cell disease

depression alcoholism drug addiction

inherited/genetic disorder: _____

cancer: (type): _____

Other: _____

SOCIAL HISTORY

Please circle any stresses in your household or environment:

Job difficulties Money worries

Separation/divorce Domestic Violence

Mental Illness Drug/alcohol abuse

Other: _____

Is your ch ild always securely fastened in a car seat/ seatbelt while riding in the car?

☐ **YES** ☐ **NO**

Are there any smokers in the household or childcare setting? ☐ **YES** ☐ NO

Is there anything else not else where listed that you think we should be made aware?

_____

_____

_____

_____

_____

_____