

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: _____

DELIVERY / BIRTH HISTORY: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:
_____ RESPOND TO SOUND _____ CRAWL
_____ FOLLOW AN OBJECT WITH HIS/HER EYES _____ STAND
_____ HOLD HEAD UP _____ WALK ALONE
_____ SIT ALONE _____

CHILDHOOD DISEASES: _____ CHICKENPOX _____ RUBELLA
_____ MUMPS _____ RUBEOLA
_____ MEASLES _____ WHOOPING COUGH
OTHER: _____

HAS THIS CHILD EVER SUFFERED FROM:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Backaches	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic Earaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Colds/Flu
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies
<input type="checkbox"/> Neuritis	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Constipation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Sugar Concentration	<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscle Jerking
<input type="checkbox"/> Fainting	<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Ruptures / Hernias
<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Leg Problems	<input type="checkbox"/> "Growing Pains"
<input type="checkbox"/> Joint Problems			

PRESENT HISTORY: _____

SURGERY: _____
MEDICATIONS: _____
ACCIDENTS: _____
FAMILY HISTORY: _____