WORLDWIDE PEDIATRICS

☐ New patient
□ Updated form

Today's date: _____

Patient's Name: _____

Date of birth: _____ Age: _____ □Male □ Female

General Medical Information

Present health concerns: _____

Medication/Vitamins: _____

Allergies: _____

Previous Pediatrician treating your child if applicable:_____

Pregnancy & Birth History

Is this child yours by: □ Birth □ Adoption □ Step-child

Any problems during pregnancy or delivery? □ No □ Yes, please explain: _____

Delivery type: □ Vaginal □ C-Section Full term: □ Yes □ No, how many weeks? _____

Birth weight: _____ lbs. _____oz. Birth length: _____ in.

Which hospital did you deliver at? _____ OBGYN treating you? _____

Nutrition & Feeding

Was your child breastfed? □ No □ Yes, how long? _____

Any feeding concerns that you have for your child? _____

Immunizations

Are your child's vaccines up-to-date? □ Yes □ No

Exposure & Habits

Any concerns about lead exposure? (Older home, plumbing, peeling paint) □ Yes □ No

Do any household members smoke? □ Yes □ No

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Patient's Name: _____

Past Medical History

Any medical problems in the past?

□ Asthma □ Recurrent ear infections □ Behavioral problems □ Difficulty using the restroom

□ Urinary tract infection □ Broken bones □ Anemia □ Obesity

Any hospitalizations in the past (with dates)?

_____

_____

Has your child been seen by a dentist? □ No □ Yes, last date of visit? _____

Family History

Any history of mental illness or substance abuse in the family? □ No □ Yes, whom?

_____

High blood pressure? _____ Diabetes? _____

Heart disease? _____ Genetic disorders? _____

Stroke? _____ Bleeding/clotting disorders? _____

Asthma/COPD?_____ Cancer? (specify) _____

Social History

Who lives in the home with the child? _____

Does the child have any siblings? _____

_____

Are there any pets at home? □ No □ Yes, which type? _____

Does the child attend school or daycare? □ No □ Yes, which? _____

Is violence at home a concern? □ No □ Yes

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