Note: Parents, please complete to the best of your ability.

SILVER LAKE PEDIATRICS
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MEDICAL HISTORY FORM

Person completing this form:_____ Date_____

Relationship to child:_____ Child's primary language:_____

Child's Name:_____ Sex:_____ Date of Birth:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Home Phone ( )_____

Child's Primary Care Physician (PCP) Name:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Office Phone ( )_____ Who referred you to this clinic_____

Specific Concerns

What specifically concerns you about your child? Describe your concerns and what you hope to gain from the evaluation?

_____

_____

_____

_____

_____

_____

When were you first aware of this problem?

_____

Has your child been previously evaluated? By whom? What were you told about your child's problem?

_____

_____

_____

Composition of Family in which child currently resides:

Mother's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone ( )_____ Work Phone:( )_____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Father's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone (__)_____ Work Phone:(__)_____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Who is the child's legal guardian?_____

Persons residing in the home with child:

Name	Age	Sex	Relationship

If parent works, who cares for child?_____

Events In Family:

Have any of the following events occurred in the child's immediate family in the past year?

Family moved?	Yes ☐	No ☐
Death, divorce, separation, loss of family member?	Yes ☐	No ☐
Marriage, reconciliation, pregnancy, a new family member?	Yes ☐	No ☐
Serious injury or illness, problems with aging relatives?	Yes ☐	No ☐
Loss of work, change jobs, retirement?	Yes ☐	No ☐
Frequent serious arguments or fights?	Yes ☐	No ☐
Money problems?	Yes ☐	No ☐
Sex problems?	Yes ☐	No ☐
Drug or drinking problems?	Yes ☐	No ☐
Involvement with social services?	Yes ☐	No ☐
Out of home placement of the child?	Yes ☐	No ☐
Serious trouble with the law?	Yes ☐	No ☐
Mental illness?	Yes ☐	No ☐
Some other serious problem? (If yes, what?_____)	Yes ☐	No ☐

Agency involved:_____ Caseworker:_____

Explanation of items marked "yes":_____

Family History

Is there any history on either side of the child's biologic parents' family of the following? If yes, indicate FATHER'S or MOTHER'S side and explain WHO in remarks section showing the item number.

Item	Item Description	No	Yes	Mother's	Father's	Remarks
1	Psychological/psychiatric emotional					
2	Mental Retardation					
3	Learning Problems					
4	Birth Defects (C.P., etc...)					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/asthma					
11	Gland disorders/thyroid					
12	Hearing disorders					
13	Vision					
14	Hyperactivity					
15	Miscarriages					
16	Slow development					
17	Speech problems					
18	Other diseases in family					

All Pregnancies (include patient, deceased or miscarriages) in order:

No.	Birth Weight	Current Age	Current Grade	Health or Developmental Problems/Comments

Concerning the child being evaluated:

Did you receive prenatal care? Yes ☐ No ☐

During which month did you start prenatal care?_____

Did you smoke cigarettes during your pregnancy? Yes ☐ No ☐ If yes, how many per day?_____

Did you drink alcohol during your pregnancy? Yes ☐ No ☐ If yes, number of drinks per week?_____

Did you use any narcotic or prescription drugs during or before your pregnancy? Yes ☐ No ☐

If yes, which ones?_____ How often?_____

Did any of the following occur during pregnancy? (Check those which DID occur)

☐	decreased fetal movement	☐	morning sickness	☐	swelling
☐	high fever	☐	amniocentesis	☐	stressful events
☐	x-rays	☐	hospitalization	☐	significant trauma
☐	ultrasound	☐	operations	☐	special diet
☐	stress test	☐	accidents	☐	vaginal bleeding
☐	diabetes	☐	toxemia	☐	unusual worries
☐	high blood pressure	☐	premature labor	☐	any other problem(s)

Please explain the items you checked: _____

_____

_____

Child's Birth

At birth of child - Mother's age:_____ Father's age_____

Place of child's birth: Hospital name_____

Address_____

Physician's Name_____

Was the baby born on time?_____Late?_____ Early?_____ How many weeks?_____

Any problems with labor or delivery? Yes ☐ No ☐ Explain _____

_____

_____

Type of anesthesia/pain relief/sedation_____

Delivery was by: vaginal/natural _ C-section ____ planned _____ emergency ____breech _____ forceps_____

How many days in hospital?_____

Infant's condition at birth and in nursery:_____

Birth weight: _____ Birth length: _____ Head Circumference: _____

APGAR scores: _____

Please explain anything additional or exceptional about the birth or newborn period of your child: _____

_____

_____

Developmental History

Developmental Milestones: State the age when your child first did each of the following. Say "No" if your child has not yet done it. If you do not remember, leave it blank.

Smiled _____

Held head erect _____

Rolled over _____

Sat alone _____

Crawled _____

Walked alone _____

Rode tricycle _____

Rode bicycle _____

Ate unaided with spoon _____

Separated easily from mother _____

Buttoned clothes _____

Dressed self _____

Imitated sound _____

Said "mama", "dada" _____

Said other single words _____

Said 2-3 word phrases _____

Followed simple directions _____

Knew colors _____

Started counting _____

Recited total alphabet _____

Did you feel your child developed quickly? _____ or slowly? _____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level - How active was your child? _____ How distractible? _____

_____

_____

Adaptability - How well did your child deal with transition and change? _____

_____

_____

Approach/Withdrawal - How well did your child respond to new places, people, and things? _____

_____

_____

Intensity - Was your child happy or unhappy? _____ Do adults notice how your child is feeling? _____

_____

Mood - What was your child's basic mood? (Check one) Happy? ☐ Sad? ☐ Angry? ☐ Quiet? ☐

Regularity - Was your child predictable in patterns of sleep, appetite, etc...?

Child's Medical History

We need as complete a medical history of your child as possible. Please complete this part. Explain any items checked "YES" in the explanation space and include as much information as possible about the item. Use more paper if necessary.

Has child ever been treated for or had a history of:

No.	Item Description	No	Yes	Explanation
1	Abdominal pain/bowel problems			
2	Allergies, including foods or drugs			
3	Anemia			
4	Birth Defects			
5	Concussion/significant head injury			
6	Dental problems			
7	Drooling			
8	Ear Infections			
9	Eating problems			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Hemorrhaging or blood disorders			
14	Hormone problems			
15	Ingesting toxins/poisons			
16	Joint or bone problems			
17	Muscular problems			
18	Seizures or convulsions			
19	Significant accidents			
20	Skin diseases			
21	Tics (eye blinking, any non-purposeful repetitive movement)			
22	Urinary problems or infections			
23	Lung or breathing problems			
24	Visual/eye problems			
25	Other			

Hospitalizations: List any hospitalizations, operations or accidents of child._____

_____

_____

Medications: List medication child currently takes:_____

_____

_____

Current Weight _____ Current Height _____

Has child been immunized? Yes ☐ No ☐ Up to date?_____

Educational History

List pre-schools and schools this child has attended:

School:	Dates:
_____	_____
_____	_____
_____	_____
_____	_____

Has this child ever repeated one or more grades? If so, which grade(s)? _____

Has this child ever been in special education, or received resource room help or tutoring?

When	Where	What kind?
_____	_____	_____
_____	_____	_____

Describe any current school problems:_____

_____

_____

Has this child ever received any developmental evaluations or testing in the past?

What type?	Where	What kind?
_____	_____	_____
_____	_____	_____

Briefly describe this child's attitude toward school:

_____

_____

_____

Other Information: Please list other items that you may feel are relevant to your child behavior?

_____

_____