DayOne
FAMILY HEALTHCARE

363 Fremont St., Suite 203
Battle Creek MI 49017
P: (269) 969-6123 F: (269) 969-6122
www.dayonehealthcare.com

PEDIATRIC/ADOLESCENT HISTORY

Name _____ **DOB**_____ **Male**___ **Female**____

Pregnancy

Were there any problems with pregnancy & delivery of this child? ____Yes ____No

If yes, please explain_____

_____

_____

Birth

Circle One: Term or Premature

Circle One: Ype of delivery: Vaginal or C-section

Length: _____ Weight: _____

Problems: _____ Jaundice _____ Respiratory distress _____ Feeding problem _____Rashes _____Breech

Other _____

_____

Hospitalizations/Operations

Name of Hospital	**Reason**		**YEAR**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental Milestones

At what age did your child do the following?

*Sit with support? _____ *Say first words? _____

*First walk? _____ *Toilet trained? _____

Medications

List any medications child is taking :

_____

_____

_____

_____

Allergies

List any allergies:

_____

_____

_____

_____

Please bring an up to date copy of your child's immunizations.

Immunizations Are the child's immunizations up to date? _____ Yes _____ No

Illnesses Check if child has, or has had:

_____Anemia _____Asthma _____Chicken pox _____Diabetes

_____Diarrhea (Chronic) _____Ear problem _____Epilepsy

_____Eye problem _____Kidney/Bladder Problems _____Liver disease

_____Jaundice _____Rheumatic fever _____Eczema (Skin rash) _____Tuberculosis

Other _____

_____

_____

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PEDIATRIC/ADOLESCENT HISTORY (continued)

Family History

Please check all that apply	Father	Mother	Sibling's
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Glaucoma			
Diabetes			
Epilepsy			
Bleeding disorder			
Kidney disease			
Thyroid disease			
Mental illness			
Other			

Social & Environmental History

Who does the child live with? _____

Is the child adopted? Y or N

Does the child wear a bike helmet? Y or N

Are there smoke detectors in the home? Y or N

Is the home tobacco free? Y or N

Does the child use a seat belt/car seat? Y or N

Is the child in school or day care? _____

If there is a gun in the home, is it out of children's reach? _____

Parent signature_____ Date_____

Physician signature_____ Date_____