PEDIATRIC CLINIC WESTBANK
151 OCHSNER BLVD. STE. F
GRETNA, LA 70056

PATIENT NAME_____
D.O.B._____ DATE_____

PAST HISTORY:

Birth weight _____ **Birth length**_____

Labor: Spontaneous_____ Induced_____ Duration_____
Delivery: Vaginal____ Caesarean____ Forceps____ Vertex____ Breech____
Term_____ Premature_____ Wks._____ Post mature _____ Wks._____

Pregnancy: Maternal illness & Medications: _____
_____
Maternal alcohol or tobacco use_____

Neonatal Course: Jaundice____ Edema_____
Resuscitation_____ Infection_____
Respiratory problems_____
Hypoglycemia_____
Other_____

Development: Sat_____ mo., Crawled_____ mo.
Walked_____ mo., Single words_____ mo.
Phrases_____ mo., School work: Grade _____
Performance: _____

Hospitalizations or surgery (date or age, diagnosis, treatment)
Performance_____
_____
_____
_____
_____

Illnesses, medications, injuries_____
_____

FAMILY HISTORY: Have any blood relatives ever had the following?

	Yes	No	Relationship		Yes	No	Relationship
Asthma				Diabetes			
Heart Disease				Obesity			
GI Disorder				Sickle Cell			
High Cholesterol				Tuberculosis			
Cancer				Kidney Disease			
Seizures				Migraines			
Alcohol/Drug Abuse				Mental Problems			

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single
Siblings – please list:

_____

How many people live in your home?	Adults	Children			
Is your child currently enrolled in daycare of school?	No	Yes	Does your child drink caffeine?	No	Yes
Does your child participate in regular exercise?	No	Yes	Any smokers at home?	No	Yes
Is there a swimming pool at home?	No	Yes	Carbon Monoxide detectors?	No	Yes
Are there smoke detectors at home?	No	Yes	Are guns kept in your home?	No	Yes
Do you use Seat belts/child safety seats?	No	Yes	Any issues we should be aware of?	No	Yes
			Please list:		

Parents Initials:_____ Provider's Initials:_____
Date:_____

LIST ANY CHANGES IN PAST, FAMILY OR SOCIAL HISTORY (PFSH) **Date**_____ **Date**_____
_____
_____
_____
_____

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REVIEW OF SYSTEMS:

PATIENT NAME _____ D.O.B. _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
HEENT:					
Headaches			Problem with vision		
Hearing problems			Ear infections		
Frequent colds/congestion					
RESP:			**CARDIC:**		
Asthma			Heart murmur		
Pneumonia			Rapid heart beats		
Bronchitis			Chest pain		
G.I.:					
Frequent stomachaches			Diarrhea		
Constipation			Hard small stools		
G.U.:					
Pain on urination			Frequent urination		
Bed wetting					
M.S.:					
Muscle pain			Joint pain		
Swelling			Redness		
NEURO:					
Seizures			Loss of consciousness		
Hyperactivity					
HEMAT:					
Anemia			Bruising		
Bleeding					
DERM:					
Skin rash			Dry skin		
Unusual color in skin					
ENDOCRINE:					
Tires easily			Sleepy		
Always feels cold			Excess weight gain		
Tingling in hands/feet			Likes salty foods		
Dry skin					

Parents Initials:_____ Provider's Initials:_____ Date:_____