Westchester Park Pediatrics
Affiliated with Boston Children's Health Physicians

PATIENT HISTORY/*HISTORIA DEL PACIENTE*

Patient's Name: _____ Date of Birth: ___/___/___ Age: _____

Your Name: _____ Relationship to child: _____

Child's Past Medical History/ *Historial Medico del paciente*

Pregnancy/Neonatal Period

Where was your child born?_____ Is the child yours by ☐birth☐adoption ☐ stepchild ☐ other_____

Pregnancy Complications ☐Yes ☐No. If yes, explain_____

Delivered by ☐ Vaginal ☐ C-Section If C-Section, explain reason_____ Complications_____

Was your child premature? ☐No ☐Yes, Born at _____ weeks. Complications_____

Apgar Scores: 1 minute_____ 5 minutes _____ Birth Weight:_____ lbs _____oz Birth Length_____

Other problems in the newborn period _____

Infancy/Childhoo/Adolescence

Has your child ever been treated for or diagnosed with: (*explain)*

☐ Asthma or Reactive Airway Disease		☐ Generic Syndrome	
☐ Wheezing or Bronchiolitis		☐ Seizures	
☐ Seasonal Allergies or Eczema		☐ Anemia	
☐ Food Allergy		☐ Broken Bone	
☐ Recurrent Ear Infections		☐ Mental retardation or learning disability	
☐ Pnemonia		☐ Depression / Anxiety	
☐ Urinary Tract Infections		☐ Other Chronic Medical Conditions	

Has your child ever been hospitalized? ☐ Yes ☐ No. If yes, explain _____

Previous Surgeries and dates _____

Please list any specialist your child is currently seeing and reason _____

_____

Medications

ALLERGIES to MEDICATIONS / VACCINES: ☐ Yes ☐ No. If yes, explain

_____

Currently on Medication: ☐ Yes ☐ No. If yes, list medications and dose _____

☐ Vitamins _____ ☐ Herbal Supplements _____ ☐ Over-the-counter meds _____

Developmental / Nutrition

At what age did your child: Walk Alone _____ Sit Alone _____ Toilet Train (day) _____ Say Words _____ 1st Period (females) _____

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

Has your child had any unusual feeding/dietary problem? ☐ No ☐ Yes, explain _____

Current milk intake: Type _____ Amount _____ oz/day

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad ☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Child's parents are ☐married ☐ unmarried ☐ divorced ☐ other _____

Childcare: ☐parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child: Watching TV _____ Computer _____ Video Games _____

Child's School Name: _____ Grade: _____

Any concerns about school performance? ☐ No ☐ Yes, explain _____

Sports/Exercise: Type: _____ How often? _____ How long? _____ mins

Family History

Do any family members have any of the following conditions:

CONDITION	MOTHER	FATHER	SIBLING	GRANDPARENT
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart Attack/Disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Please explain all positives _____

_____

Review of Systems *(Check all that Apply)*

Constitutional ☐ Fever/Chills ☐ Fatigue ☐ Unexplained weight loss/gain ☐ Excessive Thirst	**Gastrointenstinal** ☐ Nausea/Vomiting/Diarrhea ☐ Constipation/Blood in stool ☐ Abdominal Pain
Ear, Nose, and Throat ☐ Loud Voice/Hearing Problem ☐ Mouth-breathing/Smoking ☐ Ear Pain ☐ Frequent Runny Nose	**Cardiovascular** ☐ Chest Pain/Palpitations ☐ Tires easily with exertion ☐ Fainting
Respiratory ☐ Cough, short breath ☐ Chest tightness/Wheeze	**Genitourinary** ☐ Frequent or painful urination ☐ Bed Wetting frequent accidents ☐ Vaginal or Penile Discharge
Musculoskeletal ☐ Muscle pain/Weakness ☐ Joint Pain/Swelling ☐ Bone Pain	**Neurologic** ☐ Headaches ☐ Seizures ☐ Clumsiness ☐ Discharge
Other (Eye, Skin, Blood) ☐ Blurry Vision ☐ Squinting ☐ "Crossed eyes" ☐ Itchy eyes ☐ Rashes ☐ Abnormal moles ☐ Abnormal Bruising/Bleeding	**Psychiatric/Emotional** ☐ Anxiety/Stress ☐ Depression ☐ Sleep Problems ☐ Anger Concern ☐ Concerns with Attention/Impulsivity

Reviewed by: _____ Date: _____