Evergreen Pediatric Associates

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Child Information Form

Name: ________________________

D.O.B. ______________ Age: ________

Date: ______________________

SS#: _________________________

Mother's name: ______________________________

Occupation: _______________________ Age: _____

Father's name: ______________________________

Occupation: _______________________ Age: _____

Pregnancy and Birth

Pregnancy history:

Mother's age at birth: ___

	NO	YES
Any medications during pregnancy?	_____	_____
Any infections during pregnancy?	_____	_____
Any complications during pregnancy?	_____	_____
Any smoking or alcohol or drugs?	_____	_____

Birth History:

Birth weight: ______________

	NO	YES
Premature?	_____	_____
Any trouble breathing?	_____	_____
Any infections or complications?	_____	_____
Type of delivery:	_____	_____
	Vaginal	C-section

Development History: At what age did your child...

Crawl?	____________
Sit alone?	____________
Stand?	____________
Walk alone?	____________
Say his/her first words?	____________
First half sentences?	____________
First sentences?	____________
Drink from a cup?	____________
Feed him/herself?	____________
Dress his/herself?	____________

Feeding and Nutrition

Breast or bottle fed? _________________________

How often does your child feed? ________________

	NO	YES
Any feeding problems during the first 3 months?	_____	_____
Is your child's appetite usually good?	_____	_____
Is it good now?	_____	_____
Does your child take any vitamins?	_____	_____

What is your child's diet now?

____

Elimination

	NO	YES
Any problems with urination?	_____	_____
Any problems with diarrhea?	_____	_____
Any problems with constipation?	_____	_____

Family History: circle if applicable

Anemia	Tuberculosis
Asthma	Mental illness
Allergies	Thyroid disease
Cystic Fibrosis	Kidney disease
Diabetes	Birth defects
High Blood Pressure	Seizures/epilepsy
Heart Disease	Sickle Cell anemia
Thallesemia	Bleeding problems

Review of systems: Has your child had any problems with…

	NO	YES
Ear infections?	_____	_____
Eye or vision?	_____	_____
Teeth?	_____	_____
Recurrent cough?	_____	_____
Asthma?	_____	_____
Pnemonia?	_____	_____
Skin or eczema or hives?	_____	_____
Anemia?	_____	_____
Heart murmur or heart problems?	_____	_____
Seizures or convulsions?	_____	_____
Weight loss?	_____	_____
Trouble hearing?	_____	_____

Safety and Environment

	NO	YES
Do you know the temperature of the water in your pipes?	_____	_____
Is there a working smoke detector on each floor of your home?	_____	_____
Does your child use a carseat/seat belt?	_____	_____

	NO	YES
Are there any smokers in the house?	_____	_____
Does your child wear a helmet when	_____	_____
Riding a bike?	_____	_____

Do you live in a house/apartment/mobile home? __________

Is there any peeling paint in or around your home? ________