HISTORY FORM

Grace Pediatrics, LLC

Patient Name________________________________ (birthchild/ stepchild/ adopted) Date of Birth_________
Father's Name/ Occupation______________________ Mother's name/ Occupation___________________
House built before 1960: Yes____ No _____ Peeling paint _____ Parents work with lead _____________

Patient Past History (P) and Family History (F): Please check all that apply:

Condition	P	F	Condition	P	F	Condition	P	F
ADHD			Down's syndrome			Pneumonia		
Autism			Drug Abuse			Sexual Abuse		
Asthma			Fractures			Seizures		
Allergies			Genetic Disorders			Skin Disease		
Alcoholism			Headaches			Stroke		
Birth Defects			Hearing Loss			School problems		
Bleeding Disorders			Heart Disease			Sleep Problems		
Behavioral Problems			High Cholesterol			Surgeries		
Cerebral Palsy			High Blood Pressure			Snoring		
Chicken pox			Hospitalizations			Squint		
Cancer			Kidney Disease			Tuberculosis		
Diabetes			Liver Disease			Thyroid Disease		
Depression			Learning Disability			Urinary Infections		
Developmental delays			Migraines			Ulcers		

Explain Positive Responses/ other problems:

Allergies: Medications_____________ Environmental __________Latex_____ Food_____ Vaccines _____

Development: Age at which sat______ walked______ spoke sentences__________ potty trained______

Social History: Household: dad____ mom___ grandparents___ pets_____ smokers _____ Daycare ____
Parents: married____ unmarried_____ divorced____ Siblings (gender and ages)____________________
School problems__________________ Peer relations _________________ Handedness: Rt____ Lt____
Daily hours of: Play _____ TV _________ Computers _____ Video games _____ Sleep_____ Nap_________

Dietary History: Breastfed ____Eats Healthy: Yes____ Picky_____ Constipation______ Diarrhea________
Milk _____oz Juice_____ oz Soda _____oz Energy drinks ______oz Bedwetting/ urine prob ___________

Birth History: Born____ weeks Birth wt:________ Length:____ Vaginal___ C-Sec___ Problems: _________
Pregnancy: alcohol______ smoking______ drugs __________illnesses_________ medications____________
Stresses in family:_______________________________ Family Support: _____________________________

Medications taken: __________ Herbal/Home remedies: ____________Vaccines up to date: Y ____No___
Specialists seen:__________________ Dentist name: ________________Last dental visit:______________
Home Safety: Smoke Alarm: Y___N___ Car seat/ seat belt: Y___N__ Water temp set to 120:Y___ N___