

# WESTCHESTER PARK PEDIATRICS PPLC

222 N. Westchester Avenue, White Plains NY 10604

(914) 761-1717

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

### Child's Past Medical History

#### Pregnancy/Neonatal Period

Where was your child born? \_\_\_\_\_

Is the child yours by  birth  adoption  stepchild  other \_\_\_\_\_

Pregnancy complications \_\_\_\_\_

Delivery by  vaginal  c-section \_\_\_\_\_

Reason for c-section \_\_\_\_\_

Complications \_\_\_\_\_

Was your child premature  No  Yes, born at \_\_\_\_\_ weeks \_\_\_\_\_

Complications \_\_\_\_\_

Apgar scores 1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_

Birth weight \_\_\_\_\_ Length \_\_\_\_\_

Other problems in the newborn period \_\_\_\_\_

#### Infancy/Childhood/Adolescence

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

Asthma or reactive airway disease \_\_\_\_\_

Wheezing or bronchiolitis \_\_\_\_\_

Seasonal allergies or eczema \_\_\_\_\_

Food allergy \_\_\_\_\_

Recurrent ear infections \_\_\_\_\_

Pneumonia \_\_\_\_\_

Urinary tract infections \_\_\_\_\_

Genetic syndrome \_\_\_\_\_

Seizures \_\_\_\_\_

Anemia \_\_\_\_\_

Broken bone \_\_\_\_\_

Mental retardation or learning disability \_\_\_\_\_

Depression/anxiety \_\_\_\_\_

Other chronic medical conditions \_\_\_\_\_

Has your child ever been hospitalized  No  Yes (explain) \_\_\_\_\_

Previous surgeries and dates \_\_\_\_\_

Please list any specialist your child is currently seeing and reason: \_\_\_\_\_

#### Medications

ALLERGIES to medicine/vaccines (list and describe reaction) \_\_\_\_\_

Current medications and dose: \_\_\_\_\_

Vitamins \_\_\_\_\_

Herbal supplements \_\_\_\_\_

Over-the-counter meds \_\_\_\_\_

#### Development/Nutrition

At what age did your child: Sit alone \_\_\_\_\_

Walk alone \_\_\_\_\_ Say words \_\_\_\_\_

Toilet train(day) \_\_\_\_\_ 1<sup>st</sup> period (females) \_\_\_\_\_

Was your child breastfed  No  Yes, how long? \_\_\_\_\_

Has your child had any unusual feeding/dietary problems? Explain. \_\_\_\_\_

Current milk intake: Type \_\_\_\_\_ Amount \_\_\_\_\_ oz/d

### 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 spend: \_\_\_\_\_

Watching TV \_\_\_\_\_ Computer \_\_\_\_\_ Video games \_\_\_\_\_

Child's school name \_\_\_\_\_ Grade \_\_\_\_\_

Any concerns about school performance?  No  Yes, explain \_\_\_\_\_

Any concerns about peer or teacher relationships?  No  Yes \_\_\_\_\_

Sports/exercise: Type \_\_\_\_\_

How often? \_\_\_\_\_ How long \_\_\_\_\_ min

### 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

Please explain all positives. \_\_\_\_\_

### Review of Systems (Check all that apply)

#### Constitutional

Fever, chills  Fatigue

Unexplained weight loss/gain

Excessive thirst

#### Ear, Nose, and Throat

Loud voice, hearing problem

Mouth-breathing, snoring

Ear pain

Frequent runny nose

#### Respiratory

Cough, short of breath

Chest tightness, wheeze

#### Musculoskeletal

Muscle pain, weakness

Joint pain, swelling

Bone pain

#### Other (eye, skin, blood)

Blurry vision  Squinting

"Crossed" eyes  Itchy eyes

Rashes  Abnormal moles

Abnormal bruising, bleed

#### Gastrointestinal

Nausea, vomiting, diarrhea

Constipation, blood in stool

Abdominal pain

#### Cardiovascular

Chest pain, palpitations

Tires easily with exertion

Fainting

#### Genitourinary

Frequent or painful urination

Bedwetting, frequent accidents

Vaginal or penile discharge

#### Neurologic

Headaches  Seizures

Clumsiness  Milestone delay

#### Psychiatric/emotional

Anxiety/stress  Depression

Sleep problem  Anger concern

Concerns with attention, impulsivity