Praful U Bhatt, M.D.
72 E. Church St.
Lock Haven, PA 17745
(570) 748-4565

PEDIATRIC HEALTH HISTORY

Completed by_____
Today's Date _____

Child's Name: _____ [ ] M [ ] F Date of Birth: _____
REASON FOR TODAY'S VISIT _____
Previous Medical Care Provider_____ Dental Care [Y] [N] Eye Exam [Y] [N]

Pregnancy & Birth

Mother's Age at pregnancy_____ Obstetrician _____
Any illness during pregnancy [Y] [N] _____
Medications during pregnancy [Y] [N] _____
(Exclude vitamins & iron) _____
Smoking – Alcohol – Street Drugs during pregnancy [Y] [N]
_____

Delivery: Premature On-time Late
(Circle all that apply) Normal Induced Prolonged
Breech C-Section

Birth Weight _____ Length _____
Birth Complications _____ Apgar _____

Problems with baby at birth:

[Y] [N] Breathing _____
[Y] [N] Jaundice _____
[Y] [N] Birth Defects _____
[Y] [N] Infections _____
Other _____
Problems soon after? Nursery/Home? _____

Past Medical History

Allergic Reactions: **Type of Reaction**
[Y] [N] Medicine _____
[Y] [N] Food _____
[Y] [N] Animals _____

[Y] [N] Latex Allergy
Medications taken on a regular basis
(exclude vitamins)_____

Immunizations up to date: [Y] [N]
Do you have a record of immunizations [Y] [N]

Hospitalization:

Date City/State Reason
_____
_____
_____

Serious Injury:

Date City/State Reason
_____
_____
_____

Has your child ever had a blood transfusion? [Y] [N]

Red Measles [Y] [N]
Chicken Pox [Y] [N]
Scarlet Fever [Y] [N]
Asthma/Wheezing [Y] [N]
Anemia [Y] [N]
Blood Transfusions [Y] [N]

Mumps [Y] [N]
Whooping Cough [Y] [N]
Eczema/Hives [Y] [N]
Hepatitis [Y] [N]
Seizures/ Epilepsy [Y] [N]
Rheumatic Fever [Y] [N]

Prematurity [Y] [N]
Bronchitis/ Bronchiolitis [Y] [N]
German (3 day) Measles [Y] [N]
Bleeding Tendencies [Y] [N]

Recurrent infections (3x or more)

Ear [Y] [N]
Throat [Y] [N]

Problems with:

Hearing [Y] [N]
Vision [Y] [N]

Other _____

Health of mother:
___ Good
___ Fair
___ Poor

Father's Age: _____

Highest Schooling completed (father):
High School [ ] 9 [ ] 10 [ ] 11 [ ] 12
College: [ ] Fr [ ] So [ ] Jr [ ] Sr
Grad School _____

Health of father:
___ Good
___ Fair
___ Poor

Feeding & Nutrition

Food Allergies: _____
_____

Appetite usually good [Y] [N]
Colic or feeding problems during first 3 months? [Y] [N]
Breast Fed [Y] [N] # of months _____
Formula Fed [Y] [N] # of months _____
Current Brand _____
Vitamins [Y] [N] Brand _____ Fluoride [Y] [N]
Special Diet [Y] [N] _____

Family Medical History

List all blood relatives of your child who have the following problem:
Use abbreviations: (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother (MF) Mother's Father, (FM) Father's Mother (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Allergies_____ Kidney Disease_____
Cancer _____ Anemia/Blood Disorder _____
HIV/AIDS _____ Asthma/Emphysema _____
Cystic Fibrosis _____ Mental Disorder/ Retardation _____Stroke_____
Drug Problem _____ Alcoholism _____
Arthritis _____ Muscular Dystrophy _____
Tuberculosis _____ Epilepsy/ Seizures _____
Heart Disease _____ Lung Disease _____
Diabetes _____ Cholesterol Problem _____
Muscle Disorder _____ Bone/Joint Disorder _____
High BP _____ Thyroid disease/disorder ____
Migraine _____ Rheumatic Fever _____
Ear/Eye Disorder _____ Skin Disease/Disorder _____
Birth Defects _____ Sudden Infant Death _____

Family Profile

Parents:
[ ] Married
[ ] Separated
[ ] Divorced
[ ] Single
[ ] Widowed

Mother's Age _____
Highest Schooling Completed (mother):
High School [ ] 9 [ ] 10 [ ] 11 [ ] 12 College: [ ] Fr [ ] So[ ] Jr [ ] Sr Grad School _____

Development & Behavior

(Please fill out information till 3 yrs. age)

Age at which child:

Lifted head: _____ Sentences: _____

Sat Alone: _____ Toilet Trained: _____

Stood: _____ Drank From Cup: _____

Walked: _____ Dressed Self: _____

First Word: _____ Bicycled: _____

Development compared to other children? _____

Grade in School _____ Problems in school [Y] [N] _____

_____

Learning Problems [Y] [N] _____

Getting Along with other children [Y] [N] _____

Behavior Problems [Y] [N] _____

Bad Habits [Y] [N] _____

Bedwetting [Y] [N] _____

Hobbies _____

Sports _____

Social Activities _____

Do you suspect your child may use:

[ ] Drugs

[ ] Alcohol

[ ] Tobacco

Have you ever noticed any of the following Warning Signs of Drug Use/Abuse?

[Y] [N] Angry Behavior

[Y] [N] Depression

[Y] [N] Changes in Appearance

[Y] [N] Changes in Attitude

[Y] [N] Changes in Friends

[Y] [N] Withdrawal from Family and Friends

[Y] [N] Skipping School

[Y] [N] Signs of Drugs in the house

Synopsis

Questions/Concerns about your child

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child has a change in health.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____ _____

Print Name of Parent, Guardian or Personal Representative Relationship to Patient