Welcome to Bryan Physician Network. To better serve / treat your child we ask that you fill out this history form to the best of your knowledge.

Date Completed: _____

Patient Name: _____ Sex: Male Female DOB: _____

What grade in school: _____ What School: _____

	YES	NO		YES	NO
Mumps			Knocked unconscious		
Measles			Tonsillitis		
German Measles			Urinary tract infection		
Chicken pox			Ear infection(s)		
Seizures			Pneumonia		
Asthma			Meningitis		
Allergies			Feeding problems		
Poison ingestion			Heart Murmur		
Broken Bones			Vision problems		

DRUG	DATE OF REACTION	WHAT HAPPENED?

DRUG	HOW OFTEN	WHAT FOR?

DATE	Describe why hospitalized, nature of surgery, what illness

Is your child up to date on all immunizations? YES NO UNSURE
Please provide a copy of his/her immunization records.

Mother's age when this child was born:	Medical problems during this pregnancy: (illnesses, infections, anemia, blood pressure, etc.)	
Number of pregnancies prior to this child:		
Medications taken during this pregnancy: List	# of days mother in hospital after birth:	Prenatal care was provided by:

Bryan Physician Network **PEDIATRIC HEALTH HISTORY**

DTM0169

Place Patient Label Here

BIRTH HISTORY

Where born:	Hours in Labor:	Problems or complications of delivery?
Who delivered baby:	Labor was: ( ) Spontaneous ( ) Induced	
Weight_____ Length_____	Was medication given during labor? ( ) Yes ( ) No	
Was baby born within 2 weeks of expected day? ( ) Yes ( ) No ( ) Early ( ) Late	Delivery was:	
	( ) Spontaneous vaginal delivery ( ) Cesarean section	
	( ) Forceps	
	Baby position:	
	( ) Head first ( ) Feet/bottom first	

NEWBORN HISTORY (FIRST FEW DAYS OF LIFE)

	YES	NO
Baby cried or breathed spontaneously within 1 or 2 minutes?		
Was baby jaundiced (yellow)?		
How many days in hospital?		
Baby's problems or complications:		

Was child breast fed? ( ) Yes ( ) No How long?

Type of Formula

DEVELOPMENTAL HISTORY

If not done currently leave blank	AGE IN MONTHS
Roll stomach to back	
Laugh out loud	
Reach out for objects	
Sit without support	
Feed self crackers	
Say dada, mama in reference to right person	
Drink from a cup	
Walk well	
Toilet trained (daytime)	
Combine (2 words)	
	AGE IN YEARS
Give first and last name	
Dress self	

SOCIAL HISTORY: Give your brief assessment in 2-3 words of your child's:

Personality	
Ways of comforting self	
Expression of anger/frustration	
Cooperation/obedience	
Fears	
Self-satisfaction/degree of happiness	
Reaction to change	
Relationship to other children	
Number of close friends	
School performance	
What concerns you most about this child?	

HAVE ANY OF YOUR CHILD'S BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING:		
	YES	NO
Anemia		
Arthritis		
Birth defect		
Bleeding tendency		
Cancer		
Deafness		
Diabetes mellitus		
Drinking or drug problem		
Epilepsy/seizures		
Glaucoma		
Heart attack or heart disease		
High blood pressure		
Mental or emotional problems		
Nerve or muscle disease		
Obesity		
Stroke		
Suicide or attempted suicide		
Tuberculosis		
Other (please list below)		

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS

NAME(S)	MALE/FEMALE	DATE OF BIRTH OR AGE	LIVING AT HOME?
Mother: Father:			
Children:			
Others living in household:			

Parent of legal guardians signature: _____ Date: _____

UPDATE TO MEDICAL PROFILE - FOR CLINIC USE ONLY

DATE	PHYSICIAN	INITIALS	DATE	PHYSICIAN	INITIALS

Place Patient Label Here