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SUNSHINE PEDIATRICS
A Children's Mercy Affiliate

(Also see Pediatric Record)

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FORM COMPLETED BY: _____ **RELATIONSHIP TO PATIENT:** _____ **NAME:** _____

TODAY'S DATE: _____ **BIRTH DATE:** _____ **LOCATION OF BIRTH (Hospital or City):** _____

FAMILY HISTORY

NAME	YEAR OF BIRTH	HEALTH PROBLEMS	AT HOME?	OCCUPATION
FATHER:				
MOTHER:				
SIBLINGS:				

PATIENT'S BIRTH HISTORY AND DEVELOPMENT

Birth Weight _____ ❑Full Term or ❑Premature ❑Vaginal Delivery or ❑C-Section Baby's condition at birth and in the newborn nursery? ❑Normal ❑Abnormal(explain)_____

Sat Alone _____ Mo. Walked Alone _____ Mo. First Words _____ Mo. Is your child's development normal as far as you know? ❑Yes ❑No

COMMENTS:

PATIENT'S PAST MEDICAL HISTORY (REVIEW OF SYSTEMS)

Has your child ever had any problems in the following areas?
Please check all that apply:

❑Allergies/Eczema	❑Eyes (glasses?)	❑Ears, nose, mouth, throat
❑Recurrent ear infections	❑Hearing	❑Heart
❑Lung problems	❑Asthma	❑Pneumonia
❑GI (stomach, intestines)	❑GU (urine, bladder, kidneys)	❑Musculoskeletal
❑Skin	❑Psychiatric/Behavior/Emotional	❑School Problems
❑Hematologic/Immunologic/Infections	❑Anemia	❑Chickenpox
❑Meningitis (Brain Infection)	❑Sickle Cell	❑Sepsis

❑Neurologic (Seizures, concussions, head injuries, etc.)

COMMENTS:

PATIENT'S PRIOR HOSPITALIZATIONS, OPERATIONS, MAJOR ILLNESSES OR SERIOUS INJURIES
(Please describe and give dates)

FAMILY HISTORY

Do parents, grandparents, or other children have any of the following? If so, check box.

❑Allergies/Eczema	❑Deafness	❑Migraine headaches
❑Asthma	❑Diabetes	❑Obesity/Size
❑Anemia	❑Heart disease/Heart attacks	❑Psychiatric diseases
❑Alcoholism	❑High blood pressure	❑Rheumatic fever
❑Bleeding disorder	❑Kidney disease	❑Seizures/convulsions
❑Blindness	❑Liver disease	❑Sickle Cell Disease/Trait
❑Cancer	❑Mental retardation	❑Thyroid Disease
❑Congenital anomalies		❑Tuberculosis

COMMENTS:

ALLERGIES ❑None

CURRENT MEDICATION

FOR THE STUDENT ATHLETE, PLEASE COMPLETE THE REVERSE SIDE OF PAGE

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