LIFEBRIDGE SUBURBAN PHYSICIANS GROUP
d/b/a LUTHERVILLE PEDIATRICS

DATE: _____

PEDIATRIC HEALTH HISTORY

Name of patient:

_____

Patient's date of birth:

_____

Child's birth history:

Weight at birth: _____
Weight at discharge: _____
Which number is this child? _____
How long was the pregnancy? _____

Was the child premature?	YES	NO
Was this a multiple birth?	YES	NO
Was delivery difficult?	YES	NO
Was it a breech delivery?	YES	NO
Was it a cesarean delivery?	YES	NO

Was there anything wrong with the child at birth? YES NO

If yes, explain: _____

_____

_____

Child's health history:

Has the child ever been diagnosed with:

Allergies?	YES	NO
Birth defects?	YES	NO
Blood disease?	YES	NO
Cancer?	YES	NO
Chronic lung disease?	YES	NO
Asthma/bronchitis?	YES	NO
Diabetes?	YES	NO
Eye disorder?	YES	NO
Ear disorders?	YES	NO
Heart problems?	YES	NO
High Blood Pressure?	YES	NO
Kidney/urinary disease?	YES	NO
Mental retardation?	YES	NO
Muscle disease?	YES	NO
Nerve Disease?	YES	NO
Psychiatric condition?	YES	NO
Rheumatic fever?	YES	NO
Tuberculosis?	YES	NO
Venereal disease?	YES	NO

Maternal and family history:

During pregnancy with this child, did the mother:

See a doctor early in pregnancy?	YES	NO
Have high blood pressure?	YES	NO
Have diabetes or sugar in urine?	YES	NO
Have albumin or protein in urine?	YES	NO
Have a urinary tract infection?	YES	NO
Have an STI, STD or HIV?	YES	NO
Have German (3 day) Measles?	YES	NO
Take prescription medication?	YES	NO
Smoke cigarettes?	YES	NO

If so, how many per day? _____

Use drugs or alcohol?	YES	NO

If yes, what and how much? _____

_____

How many children has the mother had? _____

If more than one, please list current ages.

_____

Any premature births?	YES	NO

If so, how many? _____

Number of people living in the child's home

_____

Who spends more time caring for the child?

_____

Mother's age: _____
Mother's height: _____
Father's age: _____
Father's height: _____

PLEASE COMPLETE FAMILY BACKGROUND QUESTIONNAIRE ON THE BACK OF THE SHEET

LIFEBRIDGE SUBURBAN PHYSICIANS GROUP
d/b/a LUTHERVILLE PEDIATRICS

PATIENT'S NAME: _____
DATE: _____

FAMILY DISEASES

Please check one in the appropriate box if **YES**, remember this is for only **blood relatives**

	Mother	Father	Siblings	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Allergies (food, pollen, animals, drugs)							
Alcohol/Drug Addiction							
Birth defects							
Blood diseases (anemia,sickle cell)							
Bone or joint disorders							
Cancers							
Diabetes							
Eye or hearing disorders							
Gastrointestinal Disease (Crohn's, Celiac, Inflammatory Bowel Disease)							
Heart problems							
High cholesterol							
Hypertension							
Immune System (Lupus, Sarcoid, Arthritis)							
Intellectual disability							
Kidney or urinary disease							
Learning disabilities (ADHD, Dyslexia)							
Lung disease (asthma, bronchitis)							
Mental Health Condition (Anxiety, Depression, Bipolar, Schizophrenia)							
Neurological disease (Palsy, seizure, migraine)							
Thyroid disease							
Other:							