Lehigh Valley Peds
Child and Family History

Child's Name _____ Date of Birth _____

Medication Allergies _____ Other Allergies _____

Serious Illness/Hospitalization/Surgery (include date) _____

_____

Any specialists your child sees or has seen _____

Delivery: ☐ Vaginal ☐ C-section Birthweight _____ Was your child more than 2 weeks: ☐ Early ☐ Late ☐ Breastfed?

Please check off all that apply for your child:

- ☐ convulsions/epilepsy
- ☐ concussion/head injury
- ☐ severe headaches
- ☐ febrile seizures
- ☐ eye problems
- ☐ chronic ear infections
- ☐ hearing problems
- ☐ ear tubes and date(s) _____
- ☐ many sore throats
- ☐ allergies
- ☐ asthma/wheezing
- ☐ heart murmur
- ☐ jaundice
- ☐ skin problems/eczema
- ☐ feeding problems
- ☐ bowel problems
- ☐ any surgery
- ☐ weight problems
- ☐ kidney/bladder/urinary
- ☐ broken bones
- ☐ sports injuries
- ☐ sleep problems
- ☐ speech problems
- ☐ school/learning problems
- ☐ developmental problems
- ☐ emotional problems
- ☐ discipline problems
- ☐ handicaps/disabilities
- ☐ high cholesterol
- ☐ vitamins
- ☐ fluoride supplements

_____

Describe any positives: _____

_____

Please check off all that apply for your family; indicate their relationship to your child:

- ☐ migraine/headache _____
- ☐ epilepsy/seizures _____
- ☐ glaucoma _____
- ☐ cataracts _____
- ☐ strabismus _____
- ☐ eye tumor _____
- ☐ eye/retinal cancer _____
- ☐ thyroid disorder _____
- ☐ diabetes _____
- ☐ cystic fibrosis _____
- ☐ allergies _____
- ☐ asthma _____
- ☐ TB/lung disease _____
- ☐ stroke _____
- ☐ obesity _____
- ☐ high blood pressure _____
- ☐ heart attack/ coronary artery disease _____
- ☐ heart murmurs _____
- ☐ high cholesterol _____
- ☐ kidney/urinary problems _____
- ☐ kidney cancer _____
- ☐ leukemia _____
- ☐ lymphoma _____
- ☐ colon cancer _____
- ☐ gall bladder _____
- ☐ inflammatory bowel _____
- ☐ irritable bowel _____
- ☐ hepatitis (if yes A, B or C) _____
- ☐ abnormal bleeding _____
- ☐ sickle cell anemia _____
- ☐ hip problems _____
- ☐ scoliosis _____
- ☐ arthritis/muscle disease _____
- ☐ mental retardation _____
- ☐ G6PD deficiency _____
- ☐ Marfan's disease _____
- ☐ SIDS _____
- ☐ alcoholism/addictions _____
- ☐ AIDS/HIV positive _____
- ☐ **cigarette smokers living in the home** _____
- ☐ any other cancer _____

Describe any positives: _____

_____

_____

Parent/Guardian _____ Date _____

Provider Review _____ Date _____