

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: _____

DELIVERY/ BIRTH HISTORY: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

_____	RESPOND TO SOUND	_____	CRAWL
_____	FOLLOW AN OBJECT WITH HIS/HER EYES	_____	STAND
_____	HOLD HEAD UP	_____	WALK ALONE
_____	SIT ALONE		

CHILDHOOD DISEASES: _____ CHICKENPOX _____ RUBELLA
_____ MUMPS _____ RUBEOLA
OTHER: _____ MEASLES _____ WHOOPING COUGH

HAS THIS CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chronic Earaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Muscle Jerking |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Ruptures / Hernias |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Other _____ |

PRESENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____