Almouie Pediatrics

Patient Name_____DOB_____

Abnormal prenatal history:

Gest Diabetes **Y / N**
Preclampsia **Y / N**
Maternal STD **Y / N**
GBS (+) **Y / N**
HEP B (+) **Y /N**
HIV (+) **Y / N**
Sickle (+) **Y / N**

Prenatal Exposures:

OTC Drugs **Y /N**
RX Drugs **Y/ N**
Smoking **Y / N**
Alcohol **Y / N**
Cocaine **Y / N**
Narcotics **Y / N**
IV Dugs **Y / N**

Birth History :

city/state was patient born?_____
Name of Hospital_____
Gestational Age_____Full Term? Y / N
Birth Weight_____lbs._____oz.
Maternal age at Delivery_____

Nursery History

D/c Wt_____
Jaundice *Y / N*
HEB B Vaccine Y / N
Oxygen at birth Y / N
Abnormal Hearing Y/N
Twin Y / N
Heart Murmur Y N

Delivery:

Vaginal **Y /N**
Were forceps used? **Y / N**
Vacuum? **Y / N**
C-section **Y / N**
Primary **Y__**
Secondary **Y__**
Breech **Y / N**

Recent Maternal Problems:

Nursing Problems **Y / N**
Sore Nipples **Y / N**
Nipple Itch **Y / N**
Breast Sore, No milk **Y / N**
Pain during Lactation **Y / N**
Pain after Nursing **Y / N**
Depression **Y / N**

Peripartum HX:

Prolonged ROM **Y / N**
Placental Abruption **Y / N**
Nuchal Cord **Y / N**
Amniotic Clear **Y / N**
W/Mec **Y / N**
Active Herpes **Y / N**

Apgar: *1 min*_____
5 min_____
10 min_____

You were referred here by who? SELF EMERGENCY ROOM OR OTHER ? _____

Child Past Medical History:

DERM DISORDERS	**no**	**yes**
EYE DISORDERS	**no**	**yes**
ENT DISORDERS	**no**	**yes**
ALLERGIES	**no**	**yes**
RESPIRATORY DISORDERS	**no**	**yes**
CARDIAC DISORDERS	**no**	**yes**
GI DISORDERS	**no**	**yes**
KIDNEY DISORDERS	**no**	**yes**
UROLOGICAL DISORDERS	**no**	**yes**
ENDOCRINE DISORDERS	**no**	**yes**
RHEUMATOLOGY DISORDERS	**no**	**yes**
GENETIC DISORDERS	**no**	**yes**
ORTHOPEDIC DISORDERS	**no**	**yes**
HEMATOLOGIC DISORDERS	**no**	**yes**
IMMUNOLOGIC DISORDERS	**no**	**yes**
NEUROLOGIC DISORDERS	**no**	**yes**
PSYCHIATRIC DISORDERS	**no**	**yes**

Other remarkable past history:_____

FAMILY MEDICAL HISTORY (IF YES, WHOM)

HEART DISEASE: NO YES _____
DIABETES : NO YES _____
CANCER: NO YES _____
THYROID: NO YES _____
KIDNEY DISEASE: NO YES _____
ASTHMA: NO YES _____
LUNG DISEASE: NO YES _____
LIVER DISEASE: NO YES _____
BLEEDING DISORDERS: NO YES _____
GI DISORDERS: NO YES _____
HIV: NO YES _____
SEIZURES: NO YES _____
NEUROLOGIC DISORDERS: NO YES _____
PSYCHIATRIC DISORDERS: NO YES _____
ADD/ADHD: NO YES _____
BIRTH DEFECTS: NO YES _____
ALLERGIES: NO YES _____

Prior Hospitalization History:

1. **Hospitalization History NO YES**
2. **Orbital Cellulitis____**
3. **Peritonsillar Abscess____**
4. **Retropharyngeal Abscess___**
5. **Asthma___**
6. **Bronchiolitis___**
7. **Pneumonia___**
8. **Influenza___**
9. **Pleural Effusion___**
10. **Dehydration___**
11. **Gastroenteritis___**
12. **Rotavirus___**
13. **Abdominal Pain___**
14. **Headache___**
15. **Concussion___**
16. **Febrile Seizure___**
17. **Epilepsy___**
18. **Fracture___**
19. **Osteomyelitis___**

Hyperbilirubinemia___
Failure to thrive___
Over Dose___ Intentional___
Eating Disorder___
Substance Abuse___
Other:_____

Surgical History:

Surgical History NO YES
Head & Skull Surgery___ **Other:_____**
Eye Surgery___
ENT Surgery___
Ear Tubes___
Adenoidectomy___
Tonsillectomy___
Oral Surgery___
Cardiothoracic Surgery___
Heart Surgery___
Abdominal Surgery___
Appendectomy___
Inguinal Hernia Repair___
Kidney Surgery___
Urologic Surgery___
Circumcision Surgery___
Hypospadias Surgery___
Orthopedic Surgery___
Knee Surgery___

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