Dr. Tolga Icli
Children Pediatric History Form

Child's Name ______________________Age _____

Your Name _________________________________

Pregnancy/Neonatal Period

Where was your child born? ___________________________
Is the child yours by: ___birth __adoption __stepchild __other
Delivery: __vaginal __c-section
Was your child premature? __No __Yes, born at _____weeks.
Birth Weight _______________ Length __________________
Other problems in the newborn period ___________________
____

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with: (Explain)
__ Asthma or reactive airway disease __________________
__Wheezing or Bronchiolitis _________________________
__Seasonal Allergies _______________________________
__Eczema _____________________________________
__Food Allergy _________________________________
__Recurrent Ear Infections ________________________
__Pneumonia __________________________________
__Urinary Tract Infections ________________________
__Seizures ___________________________________
__Anemia ____________________________________
__Broken Bone _______________________________
__Depression/anxiety ___________________________
__Heart Murmur _______________________________
__Constipation ________________________________
__Chicken Pox ________________________________
__Attention Deficit Disorder _____________________
Other Chronic Medical Conditions _____________________
____
Has your child ever been hospitalized? _No _Yes(Explain)
____
Previous surgeries and dates.__________________________
____
Please list any specialist your child has seen, dates and reason.
____
____

Medications:

ALLERGIES to medicine/vaccines(list and describe reaction)
____
____
Current Medications and dose: ________________________
____
____

Development/Nutrition

Did/does your child have delayed development? __No__Yes
How does this child compare to others his/her age? _______
____
What grade is he/she in? ____________________________
Has he/she had any trouble in school? __No __Yes
Does he/she get along with other children? __No __Yes
Do any foods disagree with him/her? __No __Yes
Which ones? _____________________________________
Does he/she get fluoride? __No __Yes
How many hours per day does your child spend:
Watching TV _____ Computer _____ Video Games ______
Hobbies/extracurricular activities _____________________

Child's DOB ____________________ Age ____________

Relationship to Child: _________Today's Date_____

Social History

Who lives in the child's household?
__Mom __Dad __Step-Parent __Siblings(#___)
__Grandparents __Others __________________________
Child's parents are: _married _unmarried _divorced _ other
Mom's Occupation _________ Dad's Occupation _________
Childcare? _ parents _relatives _daycare _babysitter/nanny
Days per week in childcare(not with parent) ______________
Any pets? __No __Yes ______________________________
Do any household members smoke? __No __Yes

Family History

Do any family members have the following conditions.

Condition	Mother	Father	Sibling	Grandparent
Asthma	__	__	__	__
Allergies	__	__	__	__
Anemia	__	__	__	__
Blood Disorder	__	__	__	__
Cancer	__	__	__	__
Diabetes	__	__	__	__
High Cholesterol	__	__	__	__
High Blood Pressure	__	__	__	__
Heart Attack/Disease	__	__	__	__
Thyroid Disease	__	__	__	__
Kidney Disease	__	__	__	__
Seizures	__	__	__	__
Migraines	__	__	__	__
Autism	__	__	__	__
Depression/anxiety	__	__	__	__
Alcoholism	__	__	__	__
ADD/ADHD	__	__	__	__
Other Issues	__	__	__	__

Please explain all positives ______________________
____

Review of Systems

Please review the topics listed below.
Check if you have a concern about your child.

Physical Problem ________
Development ________
Sleep Patterns ________
Snoring ________
Diet/Nutrician/Weight ________
Amt. Of Physical Activity ________
Emotional Development ________
Relationships with Parents ________
Self Image or Self Worth ________
Depression ________
Anxiety/Stress ________
Attention/Impulsivity ________
Acting Out/ Behavior Issues ________
School grades/Absences ________
Other ____

This is to certify that I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect information about my child's health and symptoms could place my child's health at risk

____________________	____________________	_______________
Name of Parent or Guardian	Signature of Parent/Guardian	Date

________________________	__________
Signature of Reviewing Physician	Date