The Kimberton Clinic

Pediatric Patient History Form

Patient Name:_____ **Date Of Birth:**_____

Birth History Delivery: Vaginal Cesarean - Due to:	Birth Weight: Birth Length: Head Circumference:
Was this child premature? Yes No If yes, how many weeks?_____	Were there problems with the child's delivery? Yes No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?	
Was (is) this child breast fed? No Yes Formula fed? No Yes If yes which formula? Did this child have any problems with breast feeding or formula feeding?	
SOCIAL HISTORY (Circle appropriate answer)	
Parents: Married Divorced Separated Single	
Siblings- Please list:	
How many people live in your home? _____Adults _____Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes Explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No. Yes
Any pets at home? No Yes If yes, please list:	
What is your water source?	Was your home built before 1978? No Yes
Do all family members use seat belts/ car safety sets? No Yes	Biking helmets for all family members? No Yes
Any issues we should be aware of ? No Yes Please list:	

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Hospitalizations? None Yes- List:		
Surgeries? None Yes- List:		
Drug Allergies? None Yes- List:		
Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible. **** New Patients Only****		Is patient up to date on immunizations? Yes No
Has your child had chicken pox? No Yes If yes, when?		Has your child been in the ER or Urgent Care since last visit here? No Yes If yes, when and for what?
Any Chronic Illnesses: None Yes- List:		Has your child seen a sub-specialist? No Yes If yes, when?
Review of Systems		
Any lung problems?	None	Yes- List:
Any heart problems?	None	Yes- List:
Any kidney/urinary problems?	None	Yes- List:
Any bone/ muscle problems?	None	Yes- List:
Any gastro-intestinal problems?	None	Yes- List:
Any brain/nervous system problems?	None	Yes- List:
Any genital problems?	None	Yes- List:
Any skin problems?	None	Yes- List:
Any eye/ear/nose/throat problems?	None	Yes- List:
Any developmental concerns or learning problems?	None	Yes- List:
Any behavioral problems or eating disorder?	None	Yes- List:
Any regular medications (over the counter or prescription)? Include dosage and frequency		
Any medical issues we should be aware of? None Yes- List:		

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Communication Needs

Language if other than English: Child_____ Parent_____

Any special communication needs? No Yes
If yes, please explain:

Patient Portal:
Access your child's immunization records and medical history online.
Would you like to be signed up today?
Provide your email address and phone number

Email Address:_____
Phone Number:_____

Patient Rights:

Is there anything we need to know about your religion or culture in order to care for your child?
____Y ____N
If yes, please explain: