PEDIATRIC MEDICINE, P.A.

Rebecca Rocha-Davis, M.D.
Michael Ozer, M.D.
Karen Gibbons, M.D.
David M. Ross, Jr., M.D.
M. Antonieta Gonzalez, M.D.

HISTORY SHEET

Name: ______________________ Birth Date: __________ Gender: __________
Referred By: ______________________

CURRENT PROBLEMS/CONCERNS:

____
____
____
____

PAST HISTORY:

Hospitalizations/Surgery, date and diagnosis: ______________________
____
Current medications: ______________________
Allergies to medication: ______________________
Check if child has had:

- ❑ Chicken Pox
- ❑ Measles
- ❑ Recurrent tonsillitis
- ❑ Ear Infections
- ❑ Asthma
- ❑ Hepatitis
- ❑ Urine Infection
- ❑ Pneumonia
- ❑ School problems
- ❑ Allergies to foods
- ❑ Febrile Seizure
- ❑ RSV

BIRTH HISTORY:

Birth weight: __________ Feeding: Breast __________ Bottle __________
Problems as a newborn: ______________________
____
Problems in pregnancy or delivery: ______________________
____
Smoking during pregnancy? ❑ Yes ❑ No

Alcohol during pregnancy? ❑ Yes ❑ No

Medications during pregnancy? ______________________
____

GROWTH and DEVELOPMENT:

Age at which sat: ________ Walked alone: ________ Spoke single word: ________ Spoke in sentences: ________
School grade: __________ Regular class ______ Special ______
Problems/Concerns ______________________
____
____

Does anyone smoke in the home? ❑ Yes ❑ No
Does child attend daycare? ❑ Yes ❑ No

Languages spoken in the home: ______________________

FAMILY HISTORY:

Mother's age: ______________ Health problems: ______________________________

Father's age: ______________ Health problems: ______________________________

Sibling's age: ______________ Gender: _____ Problems: ____________________

______________ Gender: _____ Problems: ____________________

______________ Gender: _____ Problems: ____________________

______________ Gender: _____ Problems: ____________________

______________ Gender: _____ Problems: ____________________

Are these both the biologic (natural) parents? ☐ Yes ☐ No

If no, please explain: ____

____

____

Have any siblings died? ☐ Yes ☐ No

If yes, cause: ____________________________ Age at death: __________ Date of death: __________

Please check if any of the following diseases have occurred in close family members. If checked, please indicate which family member and brief explanation:

- ☐ Heart attacks/disease in those less than 45 years ______________________________
- ☐ Diabetes ______________________________
- ☐ Cancer ______________________________
- ☐ Epilepsy ______________________________
- ☐ Asthma/allergies ______________________________
- ☐ Kidney disease ______________________________
- ☐ Cystic fibrosis ______________________________
- ☐ Muscular dystrophy ______________________________
- ☐ Blood disorders ______________________________
- ☐ Deafness ______________________________
- ☐ Mental retardation ______________________________
- ☐ Depression/other psychiatric problems ______________________________
- ☐ Hepatitis ______________________________
- ☐ H.I.V. ______________________________
- ☐ A.D.H.D./A.D.D. ______________________________
- ☐ Other ______________________________
- ☐ Additional information ______________________________