Dr. Daniel A. Miller
Children Pediatric History Form

Child's Name _____Age _____
Your Name _____

Child's DOB _____ Age _____
Relationship to Child: _____Today's Date_____

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 _____

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