

# LAKE SHORE PEDIATRICS, LTD.

Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Patients Name \_\_\_\_\_ Sex \_\_\_\_\_

Phone – Home \_\_\_\_\_ Work Phone Mother \_\_\_\_\_ Work Phone Father \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

<b>FAMILY HISTORY</b>			<b>SOCIAL HISTORY</b>	
Mother	Date of Birth	Occupation	Pets	Adopted
Father	Date of Birth	Occupation	Smokers	Divorce
Siblings	Date of Birth / Name	Date of Birth / Name		
	Date of Birth / Name	Date of Birth / Name		

**BIRTH HISTORY** Hospital  Lake Forest  Good Shepherd  Other \_\_\_\_\_

Obstetrician Dr. \_\_\_\_\_ Type of Delivery  Vaginal  Cesarean

Length of Stay \_\_\_\_\_ Gestation \_\_\_\_\_  Full Term  Premature \_\_\_\_\_

Measurements Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Discharge Weight \_\_\_\_\_

Any Pregnancy Problems \_\_\_\_\_

Any Problems After Birth \_\_\_\_\_

Feeding  Breast  Bottle  Formula Type \_\_\_\_\_

**PATIENT HEALTH HISTORY** Has your child ever had any history of, or difficulty with any of the following?

Yes	Yes	Yes	Yes
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Strep Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Cancer	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vision Problem

Is your child currently on any medications?  Yes  No

Medications \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

Date or Age	Hospital	Reason
_____	_____	_____

Does your child have any medication, food or other allergies?  Yes  No

Allergies	Reaction
_____	_____

ALLERGY HISTORY

**FAMILY HISTORY** Do any siblings, parents, or grandparents of the patient have any of the following?

Yes	Relative	Yes	Relative	Yes	Relative
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Hearing Loss	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Disease <55yrs	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Birth Defects	_____	<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Bleeding Disorder	_____	<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Inflammatory Bowel Disease	_____	<input type="checkbox"/> Vision Problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Drug / Alcohol Abuse	_____	<input type="checkbox"/> Mental Illness	_____		_____

Medical Notes \_\_\_\_\_

