

**UNIVERSITY OF TENNESSEE, MEMPHIS
DEVELOPMENTAL PEDIATRICS
MEDICAL HISTORY**

Name: _____
Date of Birth: __/__/__
Age: years ____ months ____

Chart No: _____
Today's date: _____

Current Health

Yes No Describe

Does child have allergies to medication?			
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Current Medications			(name, dose, frequency)
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Has child ever:			
been hospitalized			
had surgery			
had head injury			
lost consciousness			
broken any bones			
been treated by psychologist/psychiatrist			
been in family counseling			
been treated for alcohol/drug problems			

Does child have problems with his/her:			
vision			
hearing			
chewing/swallowing			
frequent colds			
snoring			
breathing/asthma			
heart			
stomach (vomiting, diarrhea, constipation, pains)			
kidneys			
bladder			
skin (rashes, birthmarks)			
blood (anemia, lead poisoning)			
diabetes			

Has child ever had:			
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headaches			
blackouts			
seizures			
staring spells			
tics/nervous twitches			
paralysis			

SCHOOL HISTORY

Yes No Describe

Has child:			
had speech problems			
needed speech therapy			
had problems reading			
had problems writing			
had problems doing math			
failed any grades			

BEHAVIORAL HISTORY

Yes No Describe

Does child have any problems with:			
bed wetting			
daytime wetting			
soiling			
poor appetite			
increased appetite			
trouble sleeping			
too much sleeping			

Does child:			
fight			
lie			
steal			
destroy property			
skip			
argue with adults			
disobey rules			
use bad language			
hurt animals			
start fires			
run away from home			
use drugs			

Is child:			
too active			
impulsive			
fidgety			
too talkative			
intrusive			
easily distracted			
forgetful			
inattentive			
disorganized			

FAMILY HISTORY (Includes child's parents, grandparents, aunts, uncles, and first cousins)

	Yes	No	Describe
Does anyone have:			
mental retardation			
seizures			
deafness			
blindness			
learning problems			
hyperactivity			
genetic disorder			
speech problems			
mental illnesses			
depression			
drug/alcohol problems			

PREGNANCY/BIRTH HISTORY

Mother's Age _____

Father's Age _____

Number child _____

Type of delivery _____ vaginal _____ C section

Birth weight _____

	Yes	No	Describe
During pregnancy did mother :			
have any unusual bleeding			
have high blood pressure			
have any infections			
have diabetes (high blood sugar)			
use any medications			
during alcohol			
use tobacco			
use street drugs			

have early labor			
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Did Child:			
need oxygen/ventilator			
have infections			
need antibiotics			
have jaundice			
need blood transfusions			
have feeding problems			
have seizures			
have birth defects			

DEVELOPMENTAL HISTORY

What age does your child act like? _____(years)

Has he/she lost any abilities/skills? _____(yes, no)

What age did child:

Gross motor:

- walk alone _____ months (12)
- run _____ months (15)
- ride tricycle _____ years (3)
- ride bicycle _____ years (6)

Fine motor:

- prefer one hand _____ years (2) (right___ or left___)
- button clothes _____ years (4)
- fasten zippers _____ years (4)
- tie shoes _____ years (5)

Language:

- say first words _____ years (1)
- use two word sentences _____ years (2)
- use three word sentences _____ years (2)
- tell a story _____ years (2 1/2)
- say the alphabet _____ years (4)

Toilet train:

_____ years (2 3)