Mt. Oread Family Practice
Affiliated with Lawrence Memorial Hospital

Pediatric Form

Name ____
Date of Birth _______________ Today's Date ________________________

Reason for today's visit ____

Seen by other provider ____

CURRENT MEDICATIONS (prescription, over-the-counter, herbal)

Medication	Dose	Frequency
1)		
2)		
3)		
4)		
5)		

Drug Allergies ____

Pharmacy Name/Location: ____

Other concerns (may be addressed at future visit): ____

____

MEDICAL HISTORY
Birth weight: _____________________ Birth Length: __________________________

Prenatal problems or problems at birth? ____

Please circle if child currently has or have had any of the following:

Allergies | Asthma | Frequent Ear Infections
Anemia | Attention Deficit Disorder | Urinary tract infections

Other medical issues: ____

Surgeries: ____
Hospitalizations you have had with date/reason: ____

Is child up to date on immunizations? □ Yes □ No □ Copy provided □ Will bring copy

FAMILY MEDICAL HISTORY
(Indicate health issues of the following family member, such as cancer, heart disease, high blood pressure, mental illness, allergies, arthritis, diabetes, or any other health concerns.)

Mother: __________________________________ **Maternal Grandmother:** ___________________

Father: __________________________________ **Paternal Grandmother:** ___________________

Sister: __________________________________ **Maternal Grandfather:** ___________________

Brother: _________________________________ **Paternal Grandfather:** ____________________

We are happy to request medical records from other medical providers for documentation purposes.

DEVELOPMENT:

Do you have any concerns related to your child's development (speech, mental, physical, etc.)?

□ Yes □ No If yes, please explain: ____

Has your child ever been diagnosed with developmental or speech problems?

□ Yes □ No If yes, please explain: ____

Any discipline problems at school or home?

□ Yes □ No If yes, please explain: ____

Grade in School: ________________ Average Grades: ____

Does child miss school frequently? □ Yes □ No If yes, please explain: _______________________________

Average hours of sleep/night: _________________ Any problems with sleep? □ Yes □ No

If yes, please explain: ____

SOCIAL HISTORY

Who lives at home with the child? ____

Does anyone in the home smoke? □ Yes □ No If yes, is it: □ Outside only □ Both inside & outside

Is child in daycare? □ Yes □ No If yes, type: ____

Exercise? □ Yes □ No Frequency: __________________ Type: _____________________________

Is there a gun in the home? □ Yes □ No Is it locked up? □ Yes □ No

NUTRITION

Daily Vitamin? □ Yes □ No Enrolled in WIC? □ Yes □ No

Infants Only: □ Breast fed □ Bottle Fed □ Both Number of feedings per 24 hour period: _______

Number of stools per 24 hours: _________________ Number of wet diapers per 24 hour period: ______

Children/Toddlers: Number of servings per day of the following: ________________________

Dairy (milk/milk products): ______ Vegetables: ______ Fruit: ______ Bread/Cereal: ______

Meat/beans/eggs: ______ Fats/sweets/sugars: ______ Fluid intake (water, soda, juice, etc.): ______

Any special diet or any dietary concerns: ____

VISION/DENTAL/HEARING

Date of last eye exam: ____________________ Date of last hearing screen: _________________________

Date of last dental exam: _________________ Number of times brush teeth/day: ___________________

BLOOD LEAD SCREEING

1. Does your child live in or visit a house/apartment built before 1960 with previous, ongoing, or planned renovation or remodeling? Yes No
2. Does your child have a family member with an elevated blood lead level? Yes No
3. Does your child interact with an adult whose job or hobby involves exposure to lead? (furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights/lures, reloading shotgun shells/bullets, firing guns at a shooting range, doing home repairs/remodeling, painting/stripping paint, antique/imported toys, making pottery, ammunition/explosives, auto repair/auto body, cable/wire stripping, splicing or reproduction, ceramics, firing range, leaded glass factory, industrial machinery equipment, jewelry manufacturer/repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal/batteries, steel metalwork, molten metal or foundry work) Yes No
4. Does your child live near a lead smelter, battery plant or other lead industry? Yes No
5. Does your child live in or visit a house/apartment built before 1960? (This would include a daycare, preschool, home of a babysitter, etc.) Yes No
6. Does your child use pottery, ceramic, or crystal wear for cooking, eating or drinking? Yes No