

**PEDIATRIC HISTORY FORM/FORMULARIO DE LA HISTORIA MEDICA DE NINIOS**

Date/Fecha \_\_\_\_\_  
Child's Name/Nombre del nino(a) \_\_\_\_\_  
Age/Edad \_\_\_\_\_ Birth date/Fecha de nacimiento \_\_\_\_\_

**BIRTH HISTORY/HISTORIA DE NACIMIENTO**

Birthplace/Lugar de nacimiento \_\_\_\_\_ Yes/Si No  
Was pregnancy normal/Fue embarazo normal? \_\_\_\_\_ Yes/Si No  
Was baby full term?Nacio el bebe al tiempo de nueve meses? \_\_\_\_\_ Yes/Si No  
Was delivery normal/Tuvo un parto normal? \_\_\_\_\_ Yes/Si No  
Birth weight/Peso al nacer? \_\_\_\_\_ Birth length/Cuanto midio al nacer? \_\_\_\_\_  
Any nursery problems/Tuvo algun problema recién nacido? \_\_\_\_\_ Yes/Si No  
Ethnic Background? Nacionalidad: (Circle) Black/American Indian/Asian/Filipino/Pacific Islander  
White/other \_\_\_\_\_

**GROWTH AND DEVELOPMENT/CRECIMIENTO Y DESARROLLO**

Diet/Dieta: \_\_\_\_\_  
Are you using special diets/Esta usted en dietas especiales? \_\_\_\_\_ Yes/Si No  
Are you taking fluoride/Esta tomando fluoruro? \_\_\_\_\_ Yes/Si No  
Ages when first/Edad cuando primero:  
Rolled/Se dio vuelta \_\_\_\_\_ First word/Primera palabra \_\_\_\_\_  
Sat down/Se sento \_\_\_\_\_ Walked/Camino \_\_\_\_\_  
Crawled/Gateo \_\_\_\_\_ Put words together/Unio palabras \_\_\_\_\_  
Age discontinued bottle/Edad a la que dejo la botella \_\_\_\_\_  
School History/Historia escolar:  
Year in school/Año en la escuela \_\_\_\_\_ Grade averaged/Promedio escolar \_\_\_\_\_  
School Name/Nombre de la escuela: \_\_\_\_\_  
Attends special school or classes/asiste escuela o clases especiales? \_\_\_\_\_ Yes/Si No

**PAST MEDICAL HISTORY/HISTORIA MEDICA PASADA**

Does your child take any medications?/Tomas un nino(a) algun medicamento? \_\_\_\_\_ Yes/Si No  
If so, what kind/Si asi es, que tipo? \_\_\_\_\_  
Allergic reactions (Drugs, Asthma, Hives, Eczema, Hay Fever)/Reacciones alergicas(Drogas, Asma, Ronchas, Exceema, \_\_\_\_\_

**LEAD LEVEL/NIVEL DE PLOMO** Date/Fecha \_\_\_\_\_ Results/Resultados \_\_\_\_\_  
**TUBERCULOSIS** Date/Fecha \_\_\_\_\_ Results/Resultados \_\_\_\_\_

Hospitalizations/Hospitalizaciones: When, Where, Why/Cuando, Donde, Porque? \_\_\_\_\_  
Surgery/Operaciones: \_\_\_\_\_  
Serious Injuries/Heridas Graves: \_\_\_\_\_

Any problems with/Algun problema con:  
Seizures/Convulsiones \_\_\_\_\_ Yes/Si No  
Diabetes/Diabetes \_\_\_\_\_ Yes/Si No  
Asthma/Asma \_\_\_\_\_ Yes/Si No  
Hay Fever/Alergia Nasal \_\_\_\_\_ Yes/Si No  
Heart Disease/Enfermedades del Corazon \_\_\_\_\_ Yes/Si No  
Eczema/Eczema \_\_\_\_\_ Yes/Si No  
Ulcers/Ulceras \_\_\_\_\_ Yes/Si No  
Cancer/Cancer \_\_\_\_\_ Yes/Si No  
Bed-wetting/Moja la cama \_\_\_\_\_ Yes/Si No  
Speech-Hearing Problems/Problemas de hablar-audicion \_\_\_\_\_ Yes/Si No  
Any behavioral problems:Algun problema de comportamiento: \_\_\_\_\_ Yes/Si No

**(CONT). PEDIATRIC HISTORY FORM/FORMULARIO DE LA HISTORIA MEDICA DE NINIOS**

Rebellious/Rebeldia \_\_\_\_\_ Yes/Si No  
Difficulty Concentrating/Dificultades de concentracion \_\_\_\_\_ Yes/Si No  
Cries easily/Llora facilmente \_\_\_\_\_ Yes/Si No  
Fearful/Es temeroso(a) \_\_\_\_\_ Yes/Si No  
School problems/Problemas en la escuela \_\_\_\_\_ Yes/Si No  
Other/Otro \_\_\_\_\_ Yes/Si No  
Contagious Diseases(What age)?/Enfermedades Contagiosas (A que edad)?  
Measles/Sarampon Yes/Si No \_\_\_\_\_ Chickenpox/Viruelas Yes/Si No \_\_\_\_\_  
Mumps/Paperas Yes/Si No \_\_\_\_\_ Scarlet Fever/Escariatina Yes/Si No \_\_\_\_\_  
Any other/Alguna otra? Yes/Si No \_\_\_\_\_

**GENERAL SURVEY/ ESTUDIO GENERAL**

Has your child had any unusual problems with the following:/ Su nino(a) ha tenido algun problema fuera de lo comun con lo siguiente? Eyes, Ears, Nose, Throat/Ojos, Oidos, Nariz, Garganta \_\_\_\_\_ Yes/Si No  
Heart-Lungs/ Corazon-Pulmones \_\_\_\_\_ Yes/Si No  
Stomach, Intestines/ Estomago, Intestino \_\_\_\_\_ Yes/Si No  
Kidney, Bladder/Rinones, Vejiga \_\_\_\_\_ Yes/Si No  
Blood/ Sangre \_\_\_\_\_ Yes/Si No  
Immune System/Sistema Inmulonogico \_\_\_\_\_ Yes/Si No  
Bones, Muscles/ Huesos, Musculos \_\_\_\_\_ Yes/Si No  
Tooth Decay? Caries Dentales \_\_\_\_\_ Yes/Si No  
Explain any yes answers/ Esplique las respuestas con Si \_\_\_\_\_

**FAMILY HISTORY/ HISTORIA FAMILIAR**

**LIVING/VIVEN**

**AGES NOW/EDAD**

**HEALTH/ SALUD**

Child's Father/Padre del nino(a) \_\_\_\_\_  
Child's Mother/Madre del nino(a) \_\_\_\_\_  
Brothers/Sisters of child/ Hermanos(a) del paciente \_\_\_\_\_  
How many/Cuantos \_\_\_\_\_ Do child's parents live together/Viven juntos los padres del nino(a) Yes/Si No  
Are there any smokers in the home?/Alguien fuma en la casa? \_\_\_\_\_ Yes/Si No  
Any family history of/Algun miembro de la familia padece de: Who/Quien?  
Allergies/Alergias \_\_\_\_\_ Yes/Si No  
Cancer \_\_\_\_\_ Yes/Si No  
Heart Disease/Enfermedades del Corazon \_\_\_\_\_ Yes/Si No  
Asthma/Asma \_\_\_\_\_ Yes/Si No  
Diabetes \_\_\_\_\_ Yes/Si No  
Others/Otras \_\_\_\_\_ Yes/Si No

How long has your family lived in this area/ Cuanto tiempo ha vivido su familia en esta area? \_\_\_\_\_  
Any special comments about your child/ Algun comentario especial acerca de su nino(a) \_\_\_\_\_  
Your child's last doctor was/ Quien fue el ultimo medico su nino(a)? \_\_\_\_\_

**ENVIRONMENTAL HISTORY**

Exposure to tobacco smoke/ Exposicion al tobacco \_\_\_\_\_ Yes/Si No  
Drug Use/ Usa Drogas \_\_\_\_\_ Yes/Si No  
Alcohol Use/ Usa Alcohol \_\_\_\_\_ Yes/Si No  
Tobacco use/ Fuma \_\_\_\_\_ Yes/Si No

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**PATIENT NAME:** \_\_\_\_\_  
**D.O.B.** \_\_\_\_\_

**PROVIDER SIGNATURE:** \_\_\_\_\_  
**DATE:** \_\_\_\_\_