

# PRASUNA SAJJA, M.D., P.A.

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## Pediatric History Form

Patient Name: Last Name MI First Name Sex: M / F Birth Date:

Reason for today's visit:

LIST ALL ALLERGIES AND DRUG SENSITIVITIES (SPECIFY NATURE OF REACTION)	LIST ALL MEDICATIONS TAKEN ON REGULAR BASIS INCLUDING VITAMINS AND HERBAL SUPPLEMENTS (SPECIFY DOSE AND FREQUENCY)
1)	1)
2)	2)
3)	3)
4)	4)

### BIRTH HISTORY

Is the child yours by:  Birth  Adoption  Stepchild  Other  
Medical problems during pregnancy: Yes / No, If yes, specify:  
Delivery by:  Vaginal birth  Caesarean, if Caesarean, why? If premature, how early?  
Where was the child born: Birth Weight (lbs): Birth length (in): APGAR score: 1 min \_\_\_ 5 min \_\_\_  
Any medical problems during baby's new born period: Yes / No, If yes specify:  
Other problems?

### NUTRITION AND FEEDING

Was your child breast fed? Yes/No If so, how long?  
Has your child had any unusual feeding / dietary problems? Yes / No, If yes, specify:  
Type of milk intake now:  Cow's milk ( Non fat  1% fat  2% fat  Whole)  Soy milk  Rice milk  
Average ounces per day (note: 8 ounces = 1 cup):

### SLEEP

Hours / night: Naps (number / length): Any sleep problems:

### DEVELOPMENT

At what age did your child: Sit alone: Walk alone: Say words: Toilet train (day time):  
Age at 1st menstrual period (*Girls only*):

### DENTAL HISTORY

Has child been seen by a dentist? Yes/No, If so, how often? Date of last visit:

### LIST ANY INFECTIOUS DISEASES (PRESENT YOUR CHILD'S IMMUNIZATION RECORDS)

Chicken Pox: Yes / No	Date:	Rubella: Yes / No	Date:
Measles: Yes / No	Date:	Tuberculosis (TB) : Yes / No	Date:
Meningitis: Yes / No	Date:	Other: _____	Date:
Mumps: Yes / No	Date:	Other: _____	Date:

### EXPOSURE / HABITS

Any concerns about lead exposure (old home / plumbing / peeling paint)? Yes / No Do any household members smoke? Yes / No  
TV (Hrs / day): Computers (Hrs / day): Video games (Hrs / day):

ANY MAJOR MEDICAL PROBLEMS (SPECIFY DATE)	LIST ALL PRIOR HOSPITALIZATIONS (SPECIFY DATE / REASON)
1) Date:	1)
2) Date:	2)
3) Date:	3)

Broken bones or severe sprains:

### FAMILY ILLNESS HISTORY (please indicate family members – parent, sibling, grandparent, aunt, uncle) with any of the following conditions

Illness	Yes/No	Relationship	Illness	Yes/No	Relationship
Alcoholism			Genetic disorders		
Asthma/COPD			Heart disease		
Bleeding or clotting disorder			High blood pressure		
Cancer: Type _____			High cholesterol		
Cancer: Type _____			Stroke		
Depression/suicide			Other _____		
Diabetes			Other _____		

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## SOCIAL HISTORY

With whom does the child live with?

Are your child's parents: Married Unmarried Separated Divorced, if Divorced/Separated, When?

Mother's Occupation:

Father's Occupation:

Child care situation: Parents Others (specify who and how often)

Concerns about your child: Alcohol Use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? Yes / No

Are there guns in the home? Yes / No

Any other concerns:

## SCHOOL HISTORY

Does your child attend school or pre-school? Yes / No

Current grade:

Name of school:

Any concerns about school performance:

Any concerns about relationship with: Teachers: Yes/No

Peers: Yes/No

If more than 4 yrs old, does your child have a best friend: Yes/No

Sports / exercise: Type

How often?

How long (min)?

## REVIEW OF SYMPTOMS (please check any current problems your child has on the list below)

### General

Fevers/chills/excessive  
Sweating  
Unexplained weight loss/gain

### Eyes

Squinting/"crossed" eyes/  
Asymmetric gaze

### Ears/Nose/Throat

Unusually loud voice/hard of hearing  
Mouth breathing/snoring  
Bad breath  
Frequent runny nose  
Problems with teeth/gums

### Cardiovascular

Tires easily with exertion  
Shortness of breath  
Fainting

### Respiratory

Cough/wheeze  
Chest pain

### Gastrointestinal

Nausea/vomiting/diarrhea  
Constipation  
Blood in bowel movement

### Genitourinary

Bedwetting  
Pain with urination  
Discharge: penis or vagina

### Musculoskeletal

Muscle/joint pain

### Skin

Rashes  
Unusual moles

### Allergy

Hay fever/itchy eyes

### Neurological

Headaches  
Weakness  
Clumsiness

### Psychiatric/Emotional

Speech problems  
Anxiety/stress  
Sleep issues  
Depression  
Nail biting/thumb sucking  
Bad temper/breath holding / jealousy

### Blood/Lymph

Unexplained lumps  
Easy bruising/bleeding

If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this form must be signed by a parent, guardian, or legal representative who has the authority to act on the minor Patient's behalf. By signing this form for someone else, you as the parent, guardian, or legal representative, warrant that you have the legal authority to act on the Patient's behalf. I hereby certify that all information provided by me in this form is true, complete and accurate.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by someone other than patient, Print your name and state your legal relationship to the patient