Medical Pediatrics, Ltd.

Patient Birth & Development

Date: _____

Patient Name: _____ Male / Female DOB: _____
Last First Middle

Problems during Pregnancy? *(Include illness, vaginal bleeding, toxemia, miscarriages, etc.)* ☐ NO ☐ YES

Birth weight _____ Length _____ Preterm birth? ☐ NO ☐ YES Pregnancy # weeks _____

Jaundice? ☐ NO ☐ YES

Bilirubin lights? ☐ NO ☐ YES Congenital Defects? ☐ NO ☐ YES

Breathing Difficulty ☐ NO ☐ YES Low Apgar ☐ NO ☐ YES

Patient Developmental History *(Please give approximate age)*

Rolled over	_____	Crawled	_____	First Words	_____	Toilet Training:	
Held head up	_____	Stood Alone	_____	Sentences	_____	Bladder	_____
Sat with aid	_____	Walked	_____	First Tooth	_____	Bowel	_____
Sat alone	_____						

Patient Feeding History

Breast fed ☐ NO ☐ YES: # of months

Formula ☐ NO ☐ YES: # of months

Formula Brand _____

Vitamin Suppl. ☐ NO ☐ YES: Brand _____

Soft Foods Started ☐ NO ☐ YES: Age Started _____

Appetite ☐ GOOD ☐ POOR _____

Stools - Formed ☐ NO ☐ YES

Stools - Regular ☐ NO ☐ YES

Vomiting ☐ NO ☐ YES

Unusual behaviors ☐ NO ☐ YES *Please list:* _____

Female Patients

Onset of Menses _____ LMP _____

Days in Cycle _____

Problems _____