Pediatric New Comprehensive Exam

Pt# _____

Name_____ **Birth date** ___/___/___ **Age** ____ **Today's date** ___/___/___

Parents Name(s)_____

List Current Health Problems

Problem	Treatment/Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Any Other Medications/Vitamins

_____
_____
_____

List Any Allergies To Medications

_____
_____

Birthing History

Length of Pregnancy: ____ weeks
Type of Delivery:
____ Spontaneous Vaginal Delivery
____Induced Vaginal Delivery
____C-Section because of _____
Pregnancy Complications: _____
_____
Days in the Hospital: ____ days
Apgar Scores: ____/____

Social History

Primary Caretaker: ____Parents Other _____

Parents: ___Married ___Divorced/Separated ___Single

Sleep Patterns:

___<6 Hrs; ___ 6-8 Hrs; ___ 8-10 Hrs; ___ >10 Hrs

Siblings: Name	Birth Date
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

Nutritional Problems:

____ Food Sensitivities, _____

____ Adapting to new foods normally

Family History

Below is a list of possible familial illnesses. If any have appeared in your family, indicate while family member:

Problem	Family Member
Arthritis	_____
Asthma	_____
Alzheimer's	_____
Allergy	_____
Alcoholism	_____
Birth Defects	_____
Attention Deficit	_____
Breast Cancer	_____
Colon Cancer	_____
Diabetes	_____
Depression	_____
Emphysema	_____
Hypertension	_____
Heart Attack	_____
Heart Failure	_____
Stroke	_____
Lung Cancer	_____
Migraines	_____
High Cholesterol	_____
Psychiatric Disease	_____
Thyroid Disease	_____
Osteoporosis	_____
Parkinson's	_____
Seizures/Epilepsy	_____
Peptic Ulcers	_____
Tuberculosis	_____
Kidney Disease	_____
Liver Disease	_____
Skin Cancer	_____
GYN Cancer	_____
Other Cancer	_____
Other Problems	_____
	_____

For Female Patients

Have Menstrual Periods Started? ___yes ___no
If yes, at what age: _____ years old
Menstrual periods occur about every ____ days.
Menstrual periods last about _____ days.
Menstrual period flow appears: ___normal ___excessive
Any other problems/concerns about menstruation: _____
_____

Family Physicians of Kansas L.L.C.

Past Medical History

Problem **Description of Problem**

Allergy/Immunologic Problems: ______________________________

Attention Deficit Problems: ______________________________

Ear/Nose/Throat/Hearing Problems: ______________________________

Vision/Eye Problems: ______________________________

Cardiovascular/Heart Problems: ______________________________

Asthma/Respiratory/Lung Problems: ______________________________

Skin Problems: ______________________________

Gastrointestinal Problems: ______________________________

Genital/Urinary Problems: ______________________________

Orthopedic Problems: ______________________________

Seizure/Neurologic Problems: ______________________________

Hormonal/Endocrine Problems: ______________________________

Growth Problems: ______________________________

Speech Problems: ______________________________

Developmental Delays: ______________________________

Sleep Problems: ______________________________

Dental Problems: ______________________________

Other/Concerns: ______________________________

Past Hospitalizations/Injuries/Surgeries

Year	Description of Problem
________	______________________________
________	______________________________
________	______________________________
________	______________________________

Immunizations

(No Need To Complete If A Copy Is Attached)

Type	Dates Administered					
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
______________:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___