PEDIATRIC HISTORY FORM/ FORMULARIO DE LA HISTORIA MEDICA DE NINOS

DATE FORM FILLED OUT/ FECHA DE ESTE FORMULARIO _____
CHILDS NAME/ NOMBRE DEL NINO (A) _____
AGE/ EDAD_____ BIRTHDATE/ FECHA DE NACIMIENTO_____

A. BIRTH HISTORY/ HISTORIA DE NACIMIENTO

Birthplace/ Lugar de nacimiento _____
Was pregnancy normal/ Fue embarazo normal? _____ [YES/ SI] [NO]
Was baby full term/ Nacio el bebe al termino 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 recien nacido? _____ [YES/ SI] [NO]
Ethnic ackground/ Nacionalidad: [circle] HISPANIC BLACK AM. INDIAN
CAUCASIAN ASIAN FILIPINO PACIFIC ISLANDER

B. GROWTH AND DEVELOPMENT/ CRECIMIENTO Y DESARROLO

Diet/ Dietas:
Use special diets/ Usa dietas especiales? _____ [YES/ SI] [NO]
Taking fluoride/ Esta tomando Floruro? _____ [YES/ SI] [NO]
AGES WHEN FIRST/ EDAD CUANDO PRIMERO:
Rolled/se dio vueltas _____ First Word/ Primera palabla _____
Sat/ Se sento _____ Walked/ Camino _____
Craweled/ Gateo _____ Put words together/ Unio palabras_____
Teeth/ primer diente _____ Toilet trained/ Sabe usar el bano_____
Age discontinued bottle/ Edad a la que dejo la botella_____
School History/ Historia Escolar: Describe/ Explique:
Year in school/ Ano en la escuela: _____
Grades averaged/ Promedio escolar: _____
School Name/ Nombre de la Escuela: _____
Attends special school or classes/ Asiste escuela o classes especiales? _____ [YES/ SI] [NO]

Past Medical History/ Historia Medica Pasada
Medications (does your child take any medications?) Medicinas (toma su nino(a) algun medicamento? [YES/ SI] [NO]
If so, what kind/ Si asi es, que tipo? _____
Allergic Reaction (drugs, asthma, hives, eczema, hay fever) _____ [YES/ SI] [NO]
Reaciones Alergical (drogas, asma, ronchas, excema, alergias) _____ [YES/ SI] [NO]
Hospitalizations/ Hospitalizaciones: when, where, why/ cuando, donde, porque?
_____
Operations/ Operaciones: _____ [YES/ SI] [NO]
Dangerous Injuries/ Heridas Graves: _____ [YES/ SI] [NO]

Problems with/ Algun problema con:
Seizures/ Convulsiones [YES/ SI] [NO]
Diabetes/ Diabetes [YES/ SI] [NO]
Asthma/ Asma [YES/ SI] [NO]
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]
Wetting/ Moja la Cama [YES/ SI] [NO]
Speech-Hearing problem/ Problemas de hablar-audicion [YES/ SI] [NO]

Any behavioral problems:/Algun problema de comportamiento: _____ [YES/SI] [NO]
Rebellios/Rebeldia: _____ [YES/SI] [NO]
Difficult concentrating/Dificultades de concentracion: _____ [YES/SI] [NO]
Cries easily/Llora faciilmente: _____ [YES/SI] [NO]
Fearful/ Es temeroso(a): _____ [YES/SI] [NO]
School problems/Problemas en la escuela: _____ [YES/SI] [NO]
Other/Otro: _____ [YES/SI] [NO]

Contagiouys Diseases (What age)?/Enfermedades Contagiosas (A que edad)?

Measles/Sarampion: _____ [YES/SI] [NO]
Chickenpox/ Viuelas: _____ [YES/SI] [NO]
Mumps/ Paperas: _____ [YES/SI] [NO]
Scarlet Fever/ Escarlatina: _____ [YES/SI] [NO]
Any other/ Alguna otra? _____ [YES/SI] [NO]

D. GENERAL SURVEY/ ESTUDIO GENERAL

Has your child ever had any unusual problems with the following?
Su nino(a) ha tenido algun problema fuera de lo comun con lo siguiente?

Eyes, Ear, Nose, Throat, Heart, Lungs/ Ojos, Oidos, Nariz, Garganta, Corazon, Pulmones [YES/SI] [NO]
Stomach, Intestines/ Estomago, Intestinos [YES/SI] [NO]
Kidneys, Bladder/ Rinones, Vejiga [YES/SI] [NO]
Blood/ Sangre [YES/SI] [NO]
Immune System/ Sistema Inmunologico [YES/SI] [NO]
Bones, Muscles/ Huesos, Musculos [YES/SI] [NO]
Tooth Decay/ Caries dentales [YES/SI] [NO]
Explain any if answered Yes/ Explique las respuestas con Si _____

E. FAMILY HISTORY/ HISTORIA FAMILIEAR

Childs father/ Padre del nino(a)
LIVING/VIVEN? [YES/SI] [NO] AGE NOW/ EDAD? _____ HEALTH/SALUD _____
Childs mother/ Madre del nino(a)
LIVING/VIVEN? [YES/SI] [NO] AGE NOW/ EDAD? _____ HEALTH/SALUD _____
Brothers, Sisters of child/ Hermanos (as) del patiente HOW MANY /CUANTOS? _____
Do childs parents live together? Viven juntos los padresdel 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/ Cancer _____ [YES/SI] [NO]
Heart disease/ Enfermedades del Corazon _____ [YES/SI] [NO]
Tuberculosis/ Tuberculosis _____ [YES/SI] [NO]
Other/ Otras _____ [YES/SI] [NO]

F. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA/ CUANTO TIEMPO A VIVIDO SU FAMILIA EN ESTA AREA?

_____

Where did you live before coming to this area/ Donde vivia antes de moverse a esta area? _____

G. ANY SPECIAL COMMENTS ABOUT YOUR CHILD/ ALGUN COMENTARIO ESPECIAL ACERCA DE SU NINO(A)

_____

H. YOUR CHILDS LAST DOCTOR WAS/ QUIEN FUE EL ULTIMO MEDICO DE SU NINO(A)

_____

DOCTORS SIGNATURE _____ DATE _____

PATIENTS NAME: _____ DOB: _____ MR#: _____