PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

Date: _____

Initial Patient History

Patient Name: _____ Date of Birth: _____
☐ Male ☐ Female
Parents / Guardians Name: _____
With Whom Does Patient Live: _____

Birth History

Birth Weight: _____ Length at Birth: _____ ☐ Term ☐ Preterm _____ weeks
☐ Vaginal Delivery ☐ C-Section (If C-Section, list reason: _____)
Was child exposed to smoke, drugs, or alcohol prenatally? ☐ Yes ☐ No
Pregnancy or Delivery Complications if any: _____
Problems with baby after birth, if any: _____ Length of hospital stay _____ days

Social History

Parents Marital Status: ☐ Married ☐ Divorced ☐ Single
Are there any smokers in the home? ☐ No ☐ Yes Whom? _____
Are there any pets in the home? ☐ No ☐ Yes How many and what type? _____

Name of Sibling	Age	Name of Sibling	Age

Family History

Indicate if present in any of your child's parents, siblings, grandparents, aunts/uncles, or first cousins

√	Diagnosis	Family Member	√	Diagnosis	Family Member
	ADD / ADHD			High Cholesterol	
	Anemia / Bleeding Disorder			Immune Disorder	
	Asthma / Lung Disorder			Intestinal or Liver Disease	
	Birth Defect			Learning Problems	
	Cancer			Mental Retardation	
	Deafness / Hearing Loss			Metabolic / Muscle Disorder	
	Diabetes			Neurologic Disorder / Seizure	
	Eczema / Skin Disease			Psychiatric Disorder	
	Genetic Disease			Urinary Tract / Kidney Disease	
	Heart Disease / Stroke			Thyroid Disease	
	High Blood Pressure			Tuberculosis	

For newborn patients, may skip the remainder of the history form

PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

Past Medical History

Current Medication	Dosage

Drug Allergies? ☐ No ☐ Yes Medication & Reaction: _____

Hospitalizations / Surgeries	Date

Review of Systems

Does the patient currently have or has ever had any of the following:

√		√	
	Fevers / chills / sweating		Bed Wetting
	Unexplained weight loss / gain		Pain with urination / frequent urination
	Squinting / crossed eyes / asymmetric gaze		Discharge: penile or vaginal
	Hard of hearing		Muscle / joint aches or pain
	Mouth breathing / snoring		Rashes / unusual moles
	Chronic runny nose / congestion / sore throat		Headaches / seizures
	Problems with teeth / gums		Weakness
	Chest pain / palpitations / irregular heartbeats		Clumsiness
	Fainting		ADHD
	Tires easily with exertion		Speech Problems
	Cough / wheeze / shortness of breath		Anxiety / stress
	Asthma		Sleep issues
	Abdominal pain / nausea / vomiting / diarrhea		Depression / suicidal thoughts / self injury
	Constipation		Nail biting / thumb sucking
	Colic / reflux (gastroesophageal)		Aggressive or concerning behavior problems
	Feeding Issues		Unexplained lumps
	Blood in bowel movement		Easy bruising / bleeding
	Diabetes		Thyroid problems

Any other problems: _____