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 pates in the home? □ Yes □ No 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

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:_____