



Benton Pediatrics, Inc.

Board Certified Pediatrics

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Modified 8/6/04

PATIENT AND SOCIAL HISTORY • ALL RESPONSES ARE CONFIDENTIAL •

Patient's Full Name _____

Today's Date ____ / ____ / ____

Any Known Allergies (medicines, insects, pollen, etc)?

Patient's Date of Birth _____ Patient's Weight at Birth _____

Name of Person Filling Out Form _____

Relation to Patient _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Place of Employment of Parents – Mom _____

Dad _____

Are Parents Married to each other? Yes Or No (Circle One)

Please tell us everyone the Patient Lives With _____

Does the Patient Attend Daycare? (Yes or No) If So, Where? _____

If Old Enough For School, Please Name School And Grade the Patient

Attends _____

Do Other Children Attend Daycare? (Yes or No) If So, Where? _____

Home Schooling For Any Other Children? _____

Does Anyone In The Household Smoke? _____

Does Anyone Smoke in the Car or Van? _____

Are There Pets? Yes Or No (Circle One)

If So, What Type? _____

Religion _____ Attended House of Worship _____

Do You Have Well Water Or City Water? _____

Does Your Child See a Dentist Regularly? (Yes or No)

If So, What is the Dentist's Name? _____

Does Your Child See a Medical Specialist Regularly? (Yes or No)

If So, What is the Specialist's Name? _____

For What Condition Is The Child Being Seen? _____

CHILD'S MEDICAL HISTORY (circle all that apply)

- | | | |
|---------------------------------------|---------------------------|------------------------------|
| Allergies | Diabetes | Mono |
| Anemia | Eczema | Mumps |
| Appendicitis | Fainting | Muscular Dystrophy |
| Asthma | Febrile Seizures | Nephrotic Syndrome |
| Atopic Dermatitis | Fine Motor Delays | Overweight |
| Attention Deficit Disorder (ADD/ADHD) | Frequent Strep throat | Panic Attacks/Anxiety |
| Autism | GERD (Reflux) | Pertussis (Whooping Cough) |
| Bladder Infections | Glomerulonephritis | Pneumonia |
| Bleeding Disorder | Gross Motor Delays | Psoriasis |
| Blindness (either eye) | Hearing Loss (either ear) | Pyelonephritis |
| Bone Disease | Heart or Valve Defect | Rheumatic Heart Disease |
| Bronchitis | Heart Surgery or Repair | Rheumatoid Arthritis |
| Cancer | Hernia | Roseola |
| Cerebral Palsy | High Blood Pressure | Seizures |
| Chickenpox | High Cholesterol | Sensory Integration Disorder |
| Chronic Constipation | HIV/Aids | Severe Mood Swings |
| Chronic Cough | Hives | Speech Disorder |
| Chronic Diarrhea | Hypothyroidism | Tonsillitis (frequent) |
| Chronic Ear Infections | Kidney Infections | Tourette's Syndrome |
| Chronic Headaches | Kidney Reflux | Tuberculosis |
| Chronic Sinusitis | Lactose Intolerance | Undescended Testicle |
| Chronic Fatigue | Lazy Eye | Violent Behavior |
| Cluster Headaches | Learning Disability | Wheezing |
| Cystic Fibrosis | Low Blood Sugar | |
| Depression | Measles | |
| | Migraine Headaches | |

Other (Please State Other Conditions, Problems Or Illnesses For This Patient)

Child's Name _____

Any hospitalizations for this child? (Yes or No)

If Yes, for what reason? _____

Name of hospital: _____

Age of child at the time: _____

Any surgeries for this child? (Yes or No)

If Yes, for what reason? _____

Name of hospital: _____

Age of child at the time: _____

Any broken bones or fractures for this child? (Yes or No)

If Yes, what part of body? _____

Age of child at the time: _____

Is there anything else we should know about your child?

What would you like to discuss with us today?

Child's Name _____