PALM BEACH PEDIATRIC
HEMATOLOGY ONCOLOGY

12957 Palms West Dr
Loxahatchee, FL 33470
561 798-9119

PATIENT HISTORY

CHILD'S NAME: ____DOB________Age______
What is the reason for your visit? ____
____
Pediatrician's Name and Office Address/Phone number: ____
____
Other Doctors involved in your child's care (Name and Office Info): _________________________________
____

PRENATAL HISTORY

Was the child pre-term or full-term?________ Vaginal/C-Section?_________Birth Weight______Length_____
Did mother have any infectious illnesses during the pregnancy?__________________________________
Did mother take any medications during pregnancy? ____
Were there any complications of the pregnancy (pre-eclampsia, excessive bleeding)? ___________________
____
Were there any complications of the labor or delivery (fetal distress, forceps)? _______________________
____
Did child have any medical problems after birth (bleeding, bruising, jaundice, anemia, low platelets) ?________
____
Did the infant stay in the hospital longer than the mother? _______If so, why? ________________________
____
Hospital of Birth (Name, City, State)____

PATIENT'S PAST ILLNESSES

Has the child been given a diagnosis previously? Yes____No_____Date:__________Explain:_____________
____
Have there been any hospitalizations? ___Yes ____No
Hospital/Date/Reasons: ____
Have there been any other major medical problems? ___Yes ____No
Medical Problems (if any):____
Surgeries? Yes _____No ______Date(s):__________________Surgery:_____________________________
Any complications/excessive bleeding during surgery?____
Chickenpox in the past? ____Yes ____No Chickenpox vaccine given?_____Yes _____No
Fracture or other injury? ____Yes ____No Injury:____
Bleeding or bruising?____Yes ____No Explain:____
____
Abnormal blood counts (white cells, hemoglobin, platelets)?____Yes ____No Explain:___________________
____
Other blood work abnormal?____Yes _____No Problem:____
Immunizations up-to-date? _____Yes _____No Blood Type if known: ______________________________
Please explain any of above:____
____

MEDICATIONS , VITAMINS:
____
____
____

ALLERGIES (AND REACTIONS):
____
____
____

DIET:
____

TRANSFUSIONS IN THE PAST:
____

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FAMILY HISTORY

CHILD'S NAME: ____

Father (biological): ______________________________________ Age: __________
Medical problems: ____
Occupation: ____

Mother (biological): ______________________________________ Age: __________
Medical Problems: ____
Occupation: ____

Siblings (biological):

Name	Age	M/F	Full/Half	Medical Problem (if any)

MEDICAL CONDITIONS (in biological family)*:

Paternal Grandfather: ____

Paternal Grandmother: ____

Paternal Uncle(s): ____

Paternal Aunt(s): ____

Paternal Cousin(s): ____

Maternal Grandfather: ____

Maternal Grandmother: ____

Maternal Uncle(s): ____

Maternal Aunt(s): ____

Maternal Cousin(s): ____

* Please include any blood diseases, bleeding problems (gum, nose, heavy menstrual periods), and cancers.

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PATIENT HISTORY cont'd

CHILD'S NAME: ______________________________
Who lives at home? ________________ ________________
Who cares for child while parent(s) is/are at work? ______________________

SCHOOL PERFORMANCE
Preschool/Daycare/School?______________________Grade________
What are your child's average grades?______________________
Have there been any concerns about learning or behavior issues?______________________
____

DEVELOPMENT
Does your child have any developmental problems? ______________________
____
Activities/Hobbies?______________________
____

REVIEW OF SYSTEMS
Has she/he had frequent problems with (please mark yes/no and explain):
_____ Head: Headaches, dizziness, injury, other:______________________
_____ Eyes: Vision problems, nystagmus, pain, other: ______________________
_____ Ears: Hearing problems, infections, pain, other: ______________________
_____ Nose: Frequent congestion, sinusitis, nosebleeds, other:______________________
_____ Mouth: Gum bleeding, mouthsores, other:______________________
_____ Throat: Frequent sore throat, trouble with swallowing, other:______________________
_____ Neck: Stiffness, swollen lymph nodes, other:______________________
_____ Lungs: Pneumonia, cough, asthma, other:______________________
_____ Heart: Chest pain, shortness of breath, murmur, other:______________________
_____ Abdomen: Vomiting, frequent pain, diarrhea, constipation, other:______________________
_____ Genitourinary: Heavy periods, yeast infections, other:______________________
_____ Skin: Rash, bruising, other:______________________
_____ Neurologic: Development problems, seizures, other:______________________
_____ Endocrine: Diabetes,thyroid problems, other:______________________
_____ Limbs/Musculoskeletal: Joint pain/swelling, difficulty walking, other:______________________
_____ Hematologic: Anemia, bleeding, other:______________________
_____ Nutrition: Change in weight or diet: ______________________
_____ Pain: Sites of pain and description: ______________________
_____ Psychosocial: Depression, anxiety, other: ______________________
If yes to any of the above, please explain: ______________________
____

Are there specific problems you wish to discuss today? If so, please explain:______________________
____
____
Do you have any specific concerns about your child? If so, please explain:______________________