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STANDARD PEDIATRIC EVALUATION

Child's Name: _____

Date: _____

IS THERE A HISTORY OF ANY PROBLEMS THAT THE DOCTOR SHOULD KNOW ABOUT? CHOOSE ALL THAT APPLY.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> No Problems | <input type="checkbox"/> Eating Difficulties | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Febrile Convulsion |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Autism | <input type="checkbox"/> Congenital Anomalies |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Asperger's | <input type="checkbox"/> Inability to Thrive |
| <input type="checkbox"/> Torticollis | <input type="checkbox"/> Vision Difficulties | <input type="checkbox"/> ADD | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Enuresis (bedwetting) | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Walking Difficulties | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arm or Shoulder Condition | | <input type="checkbox"/> _____ |

Additional Notes: _____

DELIVERY INFORMATION

Delivery Type: Vaginal	C-Section	Labor Duration (Hours):	_____
Number of Births: Single	Multiple	Pushing Duration (Minutes):	_____
APGAR Score: 5 Minutes After Birth	_____	Birth Weight:	_____ lbs. _____ oz.
Were forceps used in delivery:	Yes	No	Length of Child at Birth: _____
Was vacuum extraction used during delivery:	Yes	No	Gestational Age at Birth (In Weeks): _____

WHICH VACCINES HAS THE CHILD HAD TO DATE? CHOOSE ALL THAT APPLY.

- | | | |
|--|---|---|
| <input type="checkbox"/> Received all childhood vaccinations on schedule | <input type="checkbox"/> DTP (Diphtheria, Tetanus, Pertussis combination) | <input type="checkbox"/> Human Papillomavirus (HPV/ Gardasil) |
| <input type="checkbox"/> Was not vaccinated | <input type="checkbox"/> MMR (combination) | <input type="checkbox"/> Haemophiles Influenza Type B (HbCV) |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio (OPV/ IPV) | <input type="checkbox"/> Influenza (flu) |
| <input type="checkbox"/> Measles (Separate) | <input type="checkbox"/> Mumps (Separate) | <input type="checkbox"/> Neisseria Meningitis |
| <input type="checkbox"/> Pneumococcus | <input type="checkbox"/> Rubella (Separate) | <input type="checkbox"/> Tetanus (Separate) |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Varicella | <input type="checkbox"/> Pertussis (Separate) |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |