Mason Health
Mason General Hospital • Mason Clinic

PEDIATRIC MEDICAL HISTORY - REHAB

Patient Information

Child's full name: ______________________________ Date of birth: _____________ Sex (M/F): _______

Who is completing this form? ________________________________ Relationship to child: _____________

Please list all people who live with the child:

	Name	Age	Relationship
example:	*Emily Smith*	*30*	*mother*

Type of home the child lives in: □ Multiple-level home □ Single-level home □ Apartment □ Mobile home □ Other: __________________________

Why are you bringing your child to this clinic? What are your concerns? ______________________________

____

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What are your child's strengths and interests? ____

____

____

After completion and review of this form, please sign below:

Parent/Guardian Signature: ______________________________

Date: ____________________

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Patient label

Medical Providers

Primary physician: ____

Does your child see a dentist? (yes/no): ________

Does your child see any medical specialists (yes/no): __________ If yes, which specialties?

- ◻ Audiologist
- ◻ Cardiologist
- ◻ ENT (ear-nose-throat)
- ◻ Developmental pediatrician
- ◻ Geneticist
- ◻ GI (gastroenterologist)
- ◻ Neurologist
- ◻ Ophthalmologist
- ◻ Orthopedist
- ◻ Psychologist/psychiatrist
- ◻ Other: _____________

Has your child attended therapy in the past? (yes/no): _______ If yes, which therapies?

- ◻ Physical therapy
- ◻ Occupational therapy
- ◻ Speech therapy
- ◻ Behavioral therapy
- ◻ Vision therapy

Medical History

Birth weight: _________________ Birth length: _____________________ Gestational age: ________________

Delivery method: _____________ If C-section, was it planned? (yes/no): __________

Complications during pregnancy: ____

Complications during labor: ____

Complications after delivery: ____

Is there any chance your child was exposed to alcohol, prescription drugs, or non-prescription drugs during pregnancy? (yes/no): _____

Did your child pass the newborn hearing screening? (yes/no): ______

Has your child ever had surgery? (yes/no) _______ If yes, please describe: ____________________________

____

Has your child ever had a major illness or injury? (yes/no) ________ If yes, please describe: ______________

____

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Patient label

Has your child or an immediate relative (parent or sibling) ever been diagnosed with one of the following conditions?

- ◻ ADHD------------------------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Allergies----------------------------- ◻ Child ◻ Parent ◻ Sibling allergic to: ____________
- ◻ Asthma or respiratory disease---- ◻ Child ◻ Parent ◻ Sibling
- ◻ Anemia-------------------------------◻ Child ◻ Parent ◻ Sibling
- ◻ Autism/Asperger's----------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Cerebral palsy----------------------◻ Child ◻ Parent ◻ Sibling
- ◻ Cleft lip/palate---------------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Congenital heart disease-----------◻ Child ◻ Parent ◻ Sibling
- ◻ Constipation or acid reflux--------◻ Child ◻ Parent ◻ Sibling
- ◻ Developmental delay-------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Diabetes-------------------------------◻ Child ◻ Parent ◻ Sibling type I or II: _________
- ◻ Eczema--------------------------------◻ Child ◻ Parent ◻ Sibling
- ◻ Ear Infections (3 or more in early childhood, or 3 or more in 1 year) ◻ Child ◻ Parent ◻ Sibling
- ◻ Encephalitis------------------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Failure to thrive---------------------◻ Child ◻ Parent ◻ Sibling
- ◻ Feeding disorder--------------------◻ Child ◻ Parent ◻ Sibling
- ◻ Genetic syndrome------------------ ◻ Child ◻ Parent ◻ Sibling
  which syndrome? ______________________________
- ◻ Head trauma (TBI)----------------- ◻ Child ◻ Parent ◻ Sibling age of injury: _________
- ◻ Mental illness----------------------- ◻ Child ◻ Parent ◻ Sibling
  which condition? ______________________________
- ◻ Recurrent strep throat--------------◻ Child ◻ Parent ◻ Sibling
- ◻ Seizures/epilepsy------------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Sleep disorders---------------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Speech Therapy/-------------------- ◻ Child ◻ Parent ◻ Sibling
  Physical Therapy/Occupational Therapy
- ◻ Tongue tie/lip tie/cheek tie ------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Tonsillectomy/Adenoidectomy -- ◻ Child ◻ Parent ◻ Sibling
- ◻ Urinary tract infection------------- ◻ Child ◻ Parent ◻ Sibling
- ◻ Vision Therapy/School Therapy ◻ Child ◻ Parent ◻ Sibling
- ◻ Other: ______________________ ◻ Child ◻ Parent ◻ Sibling

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Patient label

Developmental Milestones

Does your child…

	Milestone			
□	Roll tummy to back------------------------------	□ yes	□ not yet	□ not anymore
□	Roll back to tummy------------------------------	□ yes	□ not yet	□ not anymore
□	Sit independently--------------------------------	□ yes	□ not yet	□ not anymore
□	Crawl on belly (army crawl) -------------------	□ yes	□ not yet	□ not anymore
□	Crawl on all fours--------------------------------	□ yes	□ not yet	□ not anymore
□	Take first steps-----------------------------------	□ yes	□ not yet	□ not anymore
□	Walk while holding furniture------------------	□ yes	□ not yet	□ not anymore
□	Walk--	□ yes	□ not yet	□ not anymore

Patient label