

ADELANTE HEALTHCARE
PEDIATRIC INITIAL HISTORY / HISTORIA INICIAL PEDIATRICA

(Age 5 and Under)

		Date/Fecha
Child's Name / Nombre del niño		Age/ edad
Birth Date / Fecha de nacimiento	Hospital	City /Ciudad
Pregnancy / Embarazo Normal Abnormal		Explain/Explique:
Illness during pregnancy / Enfermedades durante el embarazo: Yes/Si No		Explain/Explique:
Labor / Parto: Normal Abnormal		Explain/Explique:
Delivery / Parto: Normal Abnormal		Explain/Explique:
Newborn Period / Período del recién nacido: Normal Abnormal		Explain/Explique:
Feeding / Alimentación: Breast/Pecho/Bottle/Biberón		Vitamins/Vitaminas: Yes/Sí No
Current Medications / Medicinas que esta tomando ahora		Allergies/Alergias: Yes/Sí No

Any serious illnesses, accidents or operations /Cualquier enfermedad seria, accidentes u operaciones: Yes/Sí No
Explain / Explique:

Medical problems in family, state relationship to child /Si hay problemas médicos en la familia, ¿cuál es la relación de la persona al niño?

Anemia / Anemia	Heart Disease / Enfermedad del Corazón
Arthritis / Artritis	High Blood Pressure / Alta Presión Arterial
Bleeding / Sangra	Cancer / Cáncer
Deafness / Sordera	Tuberculosis / Tuberculosis
Diabetes / Diabetis	Retardation / Retardación Mental
Thyroid Disease / Enfermedad del Tiroide	Emotional / Emocional
Asthma / Asma	Suicide / Suicidio

Physical Development/ Desarrollo Físico: At what age did your child / a que edad su bebe:

Sit up/Se sentó:	Walk/Comenzó a caminar:
Talk/Comenzó a hablar:	Feed Self/Comenzó a comer solo:
Comments/ Comentarios:	

FOR PHYSICIAN USE ONLY / SOLAMENTE PARA USO DE MEDICO

MEDICAL HISTORY

NAME _____ DATE _____

MAJOR MEDICAL PROBLEMS:

HOSPITALIZATIONS & SURGERIES:

SOCIAL HISTORY

Marital Status:	Education: _____ yrs.	Household Members:
Occupation:	Seat Belts Used: YES NO	
Counseling?		
Diet: Low Fat High Fat Vegetarian	Drugs: Non / OTC	
Alcohol: Type: _____ # of Drinks: _____ per Week or Month	Exercise: Type: _____ Frequency: _____ Duration _____	
Tobacco:	Advanced Directives: Yes No (21+ yrs of age)	
Medications: Current: _____ Past: _____		

FAMILY MEDICAL HISTORY

Father (age):	Mother (age):
Brothers (#, ages):	Sisters (#, ages):
Others:	

IMMUNIZATIONS
