Drs. Lerch, Amato & Associates
Pediatric & Adolescent Medicine

CHILD'S HISTORY INFORMATION

G. Lee Lerch, D.O.
Christopher Amato, D.O.
Kristen Beck, M.D.

Susan Horrocks, RN, APN-C
Tamara Twardowski, PA-C

63 N. Lakeview Dr., Suite 202 Gibbsboro, NJ 08026
(856) 435-6000 Fax: (856) 782-1667
445 Hurffville Cross Keys Rd., Suite B-16 Sewell, NJ 08080
(856) 256-7950 Fax (856) 256-7954

Child's Name: ______________________ Age: ____ Date Form Completed ______________________

A. BIRTH HISTORY

1. Birth Place: ______________________
2. Birth Date: ______________________
3. Was pregnancy normal: ______________________
4. Was delivery normal: ______________________
5. Was baby full term: ______________________
6. Birth Weight: ______________________
7. Birth length: ______________________
8. Any nursing problems? ______________________

B. GROWTH

1. **Age when first…**

Sat ________ Crawled ________
Rolled ________ Walked ________
First Tooth ________ Toilet Trained ________

2. **School History…**

Year in School ______ Nursery ______ Grade Averaged ______
School Name: ______________________
School Problems: ______________________
Attends Special School or classes? ______________________
Discipline or behavior problems? ______________________
Ever seen a psychologist, speech therapist, or special teacher? ______

C. HOSPITALIZATIONS

When, Where, Why? ______________________

D. SURGERY

When, Where, Why? ______________________

E. SERIOUS INJURIES

When, Where ______________________

F. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Eczema, Hay Fever) ______________________

G. FAMILY HISTORY

1. Father living? ______ Age now: ______ Healthy ______
2. Mother living? ______ Age now: ______ Healthy ______
3. Brothers/Sisters? ________ How many?: ________
   Ages ______________________
   Healthy? ______________________
4. Any family history of…
   Diabetes: ______________________
   Allergies: ______________________
   Convulsions: ______________________
   Heart Disease: ______________________
   TB: ______________________
   Cancer: ______________________
   Other: ______________________

OVER

H. PAST MEDICAL HISTORY

1. Any problems with…
   - Sleeping ____
   - Bedwetting ____
   - Weight ____
   - Height ____
   - Nail Biting ____
   - Nightmares ____
2. Diet…
   - Nursed or bottle fed? ____
   - Any colic problems? ____
   - Use special diets? ____
   - Taking vitamins? ____
   - Taking fluoride? ____
3. Contagious Diseases (what age?)
   - Measles ____
   - Mumps ____
   - Rubella (German Measles) ____
   - Chicken Pox ____
   - Scarlet Fever ____
   - Any Other? ____
4. Immunizations (shots) - Please give ages and/or dates…
   - DTP Series ____ Boosters ____
   - Smallpox ____ Boosters ____
   - Polio Series ____ Boosters ____
   - Measles ____
   - Rubella (German Measles) ____
   - Mumps ____
   - TB (Tine) test ____
   - Others ____
5. Medications (does your child take any now?)…

I. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

Where did you live before coming to this area?

J. GENERAL SURVEY

1. Has your child had any unusual problems with the following…
   - Head: ____
   - Eyes: ____
   - Ears/Nose/Throat: ____
   - Chest/Ribs/Sternum: ____
   - Heart: ____
   - Lungs: ____
   - Stomach: ____
   - Kidneys: ____
   - Bladder: ____
   - Bones/Muscles/Joints: ____
   - Skin: ____
   - Blood: ____
2. When was your child's last blood test? ____
3. When was your child's last urine test? ____

K. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

L. YOUR LAST DOCTOR WAS?

PERSON COMPLETING FORM:

Signature

Relationship to patient