Centennial Pediatrics, PC
15464 E. Orchard Rd
Centennial, CO 80016

General Information

Patient's Full Name:	Nickname:
DOB:	Male or Female (Circle One)
Parent Email Address:	Previous Physician/Office:

Birth History

Length of pregnancy: _____weeks
Did Mother have any complications during pregnancy? Yes or No
Delivery (Circle One): Vaginal or C-Section
Was baby ever breech (Circle One): Yes or No
Did baby have any problems after birth? Yes or No

Birth Weight: _____
_____
Reason? _____

Please List:
_____
_____

Current & Past Medical History

Please List:

Is the patient on any medications? (includes vitamins) Yes or No _____
Does the patient have any mental/behavioral issues? Yes or No _____
Does the patient have any academic problems? Yes or No _____
Does the patient see any specialists? Yes or No _____
Does the patient have any allergies (foods, drugs or environmental)? Yes or No _____
_____

Are immunizations up to date? Yes or No
Any reactions to immunizations? (Circle One): Yes or No _____

Please list hospitalizations, surgeries, serious illness, accidents or blood transfusions.

_____ Date: _____
_____ Date: _____
_____ Date: _____

Review of Systems (Circle all that apply):

General:
Poor Appetite
Excessive Appetite
Excessive Thirst
Under Weight
Weight Loss
Too Tall
Too Short
Difficulty Sleeping
Excessive Sleeping
Overactive
No Energy
Memory Loss
Fevers
Confusion
Skin:
Rash
Easy Bruising
Unexplained Lump
Acne
Eyes:
Pain
Blurred Vision
Crossed Eyes
Wears Glasses
Ears-Nose-Throat:
Ear Infections
Hearing Loss
Sinusitis
Frequent Nosebleeds
Mouth Breathing
Snoring
Lungs:
Chronic Cough
Shortness of Breath
Pneumonia
Wheezing/Asthma
Heart:
Murmur
High Blood Pressure
High Cholesterol
Gastrointestinal:
Abdominal Pains
Nausea/Vomiting
Diarrhea
Constipation
Frequent Indigestion/Reflux
Blood in Stools
Urinary:
Painful Urination
Frequent Urination
Day or night time wetting
Blood/Protein in Urine
Skeletal:
Leg Pains
Swollen Joints
Neuromuscular:
Headaches
Migraines
Weakness
Dizziness
Staring Spells
Fainting
Seizures
Breath Holding
Other:
_____
_____

Do you have any concerns about: hearing, vision, speech, learning problems, behavior problems? (Circle applicable) Yes or No _____
_____

Social History:

Patient's parents are (Circle One): Married, Divorced, Separated, Unmarried, Domestic Partners, Deceased (Mother/Father), Remarried (Mother/Father)
If divorced or separated – with whom does patient live and how is time divided?

_____
_____

Who lives at home with patient? (siblings, extended family, etc.):

_____
_____
_____

Father's occupation: _____ Mother's occupation: _____

Are there smokers in the home? (Circle One): Yes or No

Are there any animals, birds, or reptiles in the home? (Circle and list) Yes or No _____

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Patient's Full Name: _____ DOB: _____

Family History:

Have any of the patient's blood relatives had any of the following diseases? **If yes, please list the family member.**

		Relationship to Patient			Relationship to Patient
Alcohol/drug abuse:	Yes or No	_____	High Blood Pressure:	Yes or No	_____
Allergies:	Yes or No	_____	High Cholesterol:	Yes or No	_____
Anxiety:	Yes or No	_____	Kidney Disease:	Yes or No	_____
Arthritis:	Yes or No	_____	Lupus:	Yes or No	_____
Asthma:	Yes or No	_____	Migraines:	Yes or No	_____
Autoimmune:	Yes or No	_____	Neurologic:	Yes or No	_____
Blood Clots:	Yes or No	_____	Ophthalmology:	Yes or No	_____
Blood Disorders:	Yes or No	_____	Respiratory:	Yes or No	_____
Cancer:	Yes or No	_____	Seizures:	Yes or No	_____
Celiac Disease:	Yes or No	_____	Skin:	Yes or No	_____
Crohn's Disease:	Yes or No	_____	Stroke:	Yes or No	_____
Depression:	Yes or No	_____	Thyroid:	Yes or No	_____
Diabetes:	Yes or No	_____	Ulcerative Disease:	Yes or No	_____
Eczema:	Yes or No	_____	Other:	Yes or No	_____
Gastrointestinal:	Yes or No	_____			_____
Genetic:	Yes or No	_____			_____
Genitourinary:	Yes or No	_____			_____
Heart Disease:	Yes or No	_____			

Form completed by: _____ Relationship: _____ Date: _____