Parkway Pediatrics LLC – Kelli M. Cocke, M.D.

Patient Name: _____ *Feel free to write in margins, circle, abbreviate*

Pregnancy / Birth History:

1. Any complications or medications taken during the pregnancy? _____
2. Who was OBGYN? _____ Who was Pediatrician at Hospital? _____
3. Where was baby delivered? _____
4. How many gestational weeks completed? (Full term, or premature)? _____
5. What was the birth weight? Length? _____
6. Type of delivery? (SVD, C/S, Induction)_____
7. Complications of delivery or nursery stay? _____
8. Any abnormalities with Newborn Screen (PKU) or Hearing Screen? _____

Newborn Care:

1. Formula-fed, Breast-fed, Both? _____ Which Formula? _____
2. Feeding amount? (1-2 oz, 2-3oz, both breasts)_____ Frequency?(every 2, 3 hours)_____
3. Spitting up? _____ Amount? _____ Frequency? _____ Content?_____
4. In last 24hr : Urine diapers? _____ Stool diapers? _____ Color? _____
5. Sleeping schedule? _____
6. Water source for mixing formula? (nursery water, bottled water, tap) _____
7. IF boy baby, circumsized? _____ By whom? _____
8. Any concerns? _____
9. Plans for Daycare, Stay at home with mom, Sitter? _____
10. Receiving all recommended immunizations? Some? _____

Review of Systems: (circle any areas of concern)

1. General: fever/chills; excessive weight gain/loss
2. Eyes: watery or red eyes, vision concerns, crossing/wandering eyes, excessive blinking
3. ENT: runny nose, nasal congestion, sneezing, sore throat, bad breath, cavities, hearing concerns
4. Resp: shortness of breath, wheezing, cough – productive, dry, constant, night-time
5. CV: palpitations, chest pain, fainting, exercise intolerance, history of murmur
6. GI: stomach pain, constipation, diarrhea, vomiting, indigestion, reflux, gallstones, blood in stool
7. GU: urinary frequency, pain urinating, genital pain, urinary bleeding, incontinence day/night
8. Derm: jaundice, rash, itchy skin, problems with hair or nails
9. Msk: joint swelling, muscle pain, leg cramps, numbness or tingling in hands/feet, history of scoliosis
10. Heme: easy or excessive bruising or bleeding, bloody noses
11. Gyn: vaginal discharge, breast enlargement, nipple discharge

Family History:

1. Any significant illness in Mom/Dad, siblings? _____
2. Grandparents alive/ deceased – cause of death, serious health concerns? _____
3. Mother's height? _____ Father's height? _____
4. Any family very short? _____ Very tall? _____Underweight? _____ Overweight? _____
5. Any extended family with GENETIC DISEASES? Sickle Cell, Cystic Fibrosis, Hemophilia? _____

Social History:

1. Patient lives in house, apartment, trailer, farm, other? _____
2. With whom? Mom/ Dad, Siblings – how many, ages _____ Others? _____
3. Smokers? _____ Inside/outside? _____
4. Any pets? Inside / outside? How many, type? _____
5. Water source? City, well, other? _____ Lead Exposure? Old paint, highway/factory nearby? ____