Benton Pediatrics, Inc.

Board Certified Pediatrics

5612 NW 43rd Street • Gainesville, FL 32653-3332 • (352) 376-4542

Modified 1/28/2015

PATIENT AND SOCIAL HISTORY

• ALL RESPONSES ARE CONFIDENTIAL •

Patient's Full Name _____

Today's Date _____/_____/_____

Any Known Allergies (medicines, insects, pollen, etc)?_____

Patient's Date of Birth _____ Patient's Weight at Birth _____

Name of Person Filling Out Form _____Relation to Patient _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Place of Employment of Parents – Mom _____

Dad _____

Are Parents Married to each other? Yes Or No (Circle One)

Please tell us everyone the Patient Lives With _____

Does the Patient Attend Daycare? (Yes or No) If So, Where? _____

Name of School And Grade the Patient Attends _____

Do Other Children Attend Daycare? (Yes or No) If So, Where? _____

Home Schooling For Any Other Children? _____

Does Anyone In The Household Smoke? _____

Does Anyone Smoke in the Car or Van? _____

Are There Pets? Yes Or No (Circle One)

If So, What Type? _____

Religion _____ Attended House of Worship _____

Do You Have Well Water Or City Water? _____

Do You Have questions or concerns about:

- Drugs or Alcohol
- Domestic Violence
- HIV (particularly for patients over 13 years of age)
- Sun Exposure
- Obesity / Diet / Sedentary Lifestyle
- None of the Above

Please turn over and fill out page 2

Does Your Child See a Dentist Regularly? (Yes or No)
If So, What is the Dentist's Name? _____

Does Your Child See a Medical Specialist Regularly? (Yes or No)
If So, What is the Specialist's Name? _____

For What Condition Is The Child Being Seen? _____

CHILD'S MEDICAL HISTORY (circle all that apply)

Allergies
Anemia
Appendicitis
Asthma
Atopic Dermatitis
Attention Deficit Disorder (ADD/ADHD)
Autism
Bladder Infections
Bleeding Disorder
Blindness (either eye)
Bone Disease
Bronchitis
Cancer
Cerebral Palsy
Chickenpox
Chronic Constipation
Chronic Cough
Chronic Diarrhea
Chronic Ear Infections
Chronic Headaches
Chronic Sinusitis
Chronic Fatigue
Cluster Headaches
Cystic Fibrosis
Depression
Diabetes
Eczema
Fainting
Febrile Seizures
Fine Motor Delays
Frequent Strep throat
GERD (Reflux)
Glomerulonephitis
Gross Motor Delays
Hearing Loss (either ear)
Heart or Valve Defect
Heart Surgery or Repair
Hernia
High Blood Pressure
High Cholesterol
HlV/Aids
Hives
Hypothyroidism
Kidney Infections
Kidney Reflux
Lactose Intolerance
Lazy Eye
Learning Disability
Low Blood Sugar
Measles
Migraine Headaches
Mono
Mumps
Muscular Dystrophy
Nephrotic Syndrome
Overweight
Panic Attacks/Anxiety
Pertussis (Whooping Cough)
Pneumonia
Psoriasis
Pyelonephritis
Rheumatic Heart Disease
Rheumatoid Arthritis
Roseola
Seizures
Sensory Integration Disorder
Severe Mood Swings
Speech Disorder
Tonsillitis (frequent)
Tourette's Syndrome
Tuberculosis
Undescended Testicle
Violent Behavior
Wheezing

Other (Please State Other Conditions, Problems Or Illnesses For This Patient)

_____

_____

_____

Child's Name _____