Date_______________

Name of Child_______________________________________ DOB__________

Who lives in the home with this child:

Name	Relationship	DOB	Health Problem(s)

Are there any siblings not listed who live anywhere else?

If this child is not living with biological parent(s), does he see them?__________________________

Birth History:

Was baby born full term____

If premature, # of weeks of gestation____

Birth Weight__________lbs__________oz

Vaginal_________________________________ or ceasarean_____________________________

Indication for ceasarean____

Was baby in NICU____

Indication for NICU____

Did baby go home with mother____

Reason for staying in hospital____

Was baby formula_____________________________or breast fed_______________________

How long for breast feeding____

During pregnancy, did mother use:

Cigarettes_________________, drink alcohol________________, take prenatal vitamins_________________

Medications/drugs____

Child's Health Today

Do you believe your child is healthy____

Does your child have any serious illnesses or medical conditions_______________________

Has your child had any surgery____

Has your child ever been hospitalized____

Is your child allergic to medication______Name of Medicine___________________________

Is your child allergic to food(s)_________Name of food(s)____________________________

Do you have any concerns about ADHD, depression or anxiety___________________________

____

Patient's Medical History

Does your child have or has your child ever had: (give age, reaction, medication)

Y N	Chickenpox
Y N	Nasal allergies
Y N	Frequent ear infections
Y N	Problems with hearing
Y N	Problem with eyes or vision
Y N	Wears glasses
Y N	Congenital cataracts/retinoblastoma
Y N	Frequent headaches
Y N	Asthma
Y N	Bronchitis, bronchiolitis, pneumonia
Y N	Heart condition
Y N	Heart murmur
Y N	Blood transfusion
Y N	Anemia or bleeding problem
Y N	HIV
Y N	Organ transplant/bone marrow transplant
Y N	Cancer
Y N	Chemotherapy
Y N	Frequent abdominal pain
Y N	Constipation requiring doctor visits
Y N	Recurrent urinary tract infections
Y N	Bed-wetting (after age 5)
Y N	Kidney disease or urologic malformations
Y N	Sleep problems/snoring
Y N	Metabolic/genetic disorders
Y N	High blood pressure
Y N	Seizures or other neurologic problems
Y N	Obesity
Y N	Diabetes
Y N	Thyroid or endocrine problems
Y N	Alcohol use
Y N	Tobacco use
Y N	History of serious injuries, fractures, concussions
Y N	ADHD, anxiety, mood problems, depression
Y N	Developmental delay
Y N	Dental decay
Y N	History of family violence, physical or sexual abuse
Y N	Sexually transmitted disease
Y N	For female patients-age of onset of first period
Y N	Menstrual problems
Y N	Pregnancy
Y N	Sexually transmitted disease
Y N	Any other significant information which will help to evaluate your child's total health at the present time

Family Health History

Have any biological family members had any of the following: (indicate relationship to child)

Y	N	Childhood hearing loss_______________
Y	N	Nasal allergies_______________
Y	N	Asthma_______________
Y	N	Cigarettes_______________
Y	N	Epilepsy_______________
Y	N	Obesity_______________
Y	N	Heart disease (before age 55)_______________
Y	N	Anemia or bleeding problem_______________
Y	N	Cancer (before age 55)_______________
Y	N	Diabetes (before age 55)_______________
Y	N	Kidney disease_______________
Y	N	Tuberculosis_______________
Y	N	Liver disease_______________
Y	N	Alcohol abuse_______________
Y	N	Bedwetting (after age 10)_______________
Y	N	Drug Abuse_______________
Y	N	Dental decay_______________
Y	N	Immune difficulties, HIV, AIDS_______________
Y	N	AutoImmune disorders_______________
Y	N	High cholesterol/takes cholesterol medication_______________
Y	N	Mental illness, depression_______________
Y	N	Any other condition not mentioned above_______________

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