Patient History

Patient Name: ____________________________ Nickname: _______________

Date of Birth: _____________

Any concerns about growth or development? No Yes if yes, what are your concerns?

____

____

Has your child ever had:

☐	Measles	☐	Pneumonia	☐	Meningitis
☐	Mumps	☐	Asthma	☐	Diabetes
☐	Rubella	☐	Seizures	☐	Bladder Infection
☐	Chicken Pox	_________________		☐	Kidney Infection
☐	Frequent Strep	☐	Eczema	☐	Frequent ear infections

Other medical problems: ____

Hospitalization: ____

Surgeries: ____

Drug/Food Allergies: ____

Current Medications:

Name Dose How Often Name Dose How Often

1)_______________________________________ 3) _____________________________________

2)_______________________________________ 4) _____________________________________

<u>Pregnancy and Newborn History</u> *(Only complete if child is less than 3 years of age)*

Problems with the pregnancy? No Yes, ____

Medications during the pregnancy? No Yes, ____

Problems during labor or delivery? No Yes, ____

Was child admitted to a Special Care Nursery? No Yes, __________________________________

Type of delivery: Vaginal C-section Birth weight: _____ lbs _____oz

How many weeks along in the pregnancy were you when you delivered? __________ weeks

Medications as an infant? No Yes, ______________________________

Social History

Mother's name:______________________ Age:_____ Education:___________ Health:___________

Mother's Maiden Name: _________________________

Father's name: ______________________ Age:_____ Education:___________ Health:___________

Parent's marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

If not married, do both parents play an active role in the child's life? No Yes

Who lives in the house where the child resides? ____

____

Does the child attend daycare? No Yes, if so where? ____

In the home where the child lives:

Does anyone smoke?	No	Yes, _________________________
Well water?	No	Yes
Firearms?	No	Yes
Pets?	No	Yes, _________________________

Family History – Please list the closest relative with the following conditions:

Allergies: __________ Genetic disease:__________ Liver disease: __________

Anemia: __________ Hearing loss: __________ Mental illness: __________

Asthma: __________ Heart disease: __________ Mental retardation:_________

Autoimmune disease: __________ Heart attack<50 yrs of age: _______ Migraines: __________

Blood disorders: __________ High blood pressure:__________ Obesity: __________

Bowel problems: __________ High cholesterol:__________ Sleep disorder: __________

Cystic fibrosis: __________ Immune disorders:__________ Substance abuse: __________

Depression: __________ Kidney disease: ___________ Thyroid disorder: __________

Diabetes: __________ Learning problem:__________

Cancer (list who and type of cancer): ____

Person(s) completing this form:

Name: ____________________________ Relationship to patient: ________________ Date: ________

Name: ____________________________ Relationship to patient: ________________ Date: ________