DATE:______________ ACCT #:______________

NAME OF CHILD:____ DOB:______________

NAME AND RELATIONSHIP OF PERSON COMPLETING THIS FORM:________________________________

Has your child had any of the following:

Allergies and what kind:________________________________

____

Surgeries (type and the year):________________________

____

Hospitalizations (for what and the year):________________

____

Current health problems (diseases, syndromes, etc…)____________

____

____

Are immunizations current to your knowledge? Y/N

Is your child on any medications? Y/N

Names and dosages:____________________________

____

____

PATIENT HISTORY

Wheeze/Asthma	Y/N	Now	Past	Year
Croup	Y/N	Now	Past	Year
Pneumonia/RSV	Y/N	Now	Past	Year
Frequent Ear Infections	Y/N	Now	Past	Year
Headaches	Y/N	Now	Past	Year
Skin Condition If yes, what kind?	Y/N	Now	Past	Year_____
Frequent Diarrhea	Y/N	Now	Past	Year
Frequent Constipation	Y/N	Now	Past	Year
Urinary Tract Infections	Y/N	Now	Past	Year
Anemia	Y/N	Now	Past	Year
Seizures	Y/N	Now	Past	Year
Heart Disease	Y/N	Now	Past	Year
Diabetes	Y/N	Now	Past	Year
Depression/Anxiety	Y/N	Now	Past	Year
Behavior/Learning Problems	Y/N	Now	Past	Year
Other______________	Y/N	Now	Past	Year_____

SOCIAL HISTORY

Household members (names and ages):____________________

____

____

Household pets:________________________________

Custody of child:________________________________

Is your child exposed to second hand smoke daily? Y/N

Daycare or School?

Name of facility/school:__________________________

What was your child's birth weight? ________Lb ________Oz

Weeks gestation:________ Vaginal/C-Section

Complications:________________________________

FAMILY HISTORY

Please include child's parents, siblings, and grandparents.

No "greats" please, unless disease or syndrome persistently runs in the family.

Please indicate Mothers (maternal) or Fathers (paternal) side of family.

Example: MGM (maternal grandma), PGF (paternal grandfather)

High Blood Pressure____________________________

Heart Disease________________________________

High Cholesterol______________________________

Diabetes____________________________________

Cancer (what type)____________________________

Thyroid_____________________________________

Migraines___________________________________

Depression/Anxiety____________________________

Drug/Alcohol Addiction_________________________

Asthma_____________________________________

Seizures____________________________________

Bleeding Disorders____________________________

Anesthesia Problems___________________________

Allergies (foods, meds, etc…) and what type______________

____

Birth Defects (what kind)_______________________

Early childhood deaths (from what)________________

____

Other illnesses affecting children_________________

____

Any other inherited diseases/syndromes that run in the family?

FOR OFFICE USE ONLY

CURRENT OR PERSISTENT HEALTH PROBLEMS

DATE	DIAGNOSIS	PHYSICIAN/SPECIALIST SEEN	DATE RESOLVED

REVIEW DATES

DATE	CHANGES	DATE	CHANGES	DATE	CHANGES	DATE	CHANGES
	YES NO		YES NO		YES NO		YES NO
	YES NO		YES NO		YES NO		YES NO
	YES NO		YES NO		YES NO		YES NO