

Patient Name:

Birth Date:

MEDICATION AND ALL OTHER ALLERGIES

Please list any allergies, adverse reactions, or side-effects to medications your child may have experienced:

CURRENT MEDICATIONS

Name	Strength	Dose	Reason

PAST MEDICAL HISTORY

Chicken Pox?	Yes	No	Strep throat? Approximate number of times:	Yes	No	Tonsillitis? Approximate number of times:	Yes	No	Asthma?	Yes	No
Measles?	Yes	No	Has your child ever had an EEG (Electroencephalogram)?	Yes	No	Ear Infections? Approximate number of times:	Yes	No	Blood Transfusions?	Yes	No
Mumps?	Yes	No	Psychological evaluations?	Yes	No	Heart Murmur?	Yes	No	Cancer?	Yes	No
Rubella?	Yes	No	Hearing tests?	Yes	No	HIV/AIDS?	Yes	No	Seizures?	Yes	No
Scarlet Fever?	Yes	No	Speech/language tests?	Yes	No	Meningitis?	Yes	No	Sickle Cell?	Yes	No
Pneumonia?	Yes	No	Diabetes Mellitus?	Yes	No	Parathyroid Disorder?	Yes	No	Clotting Disorder?	Yes	No
Frequent Colds?	Yes	No	Exposure to solvents or heavy metals?	Yes	No	Adrenal Disorder?	Yes	No	Diabetes?	Yes	No
Rheumatic Fever?	Yes	No	Exposure to pesticides/herbicides or other toxic chemicals?	Yes	No	Allergies?	Yes	No	Pituitary Disease?	Yes	No
Tonsillitis? Approximate number of times:	Yes	No	Low birth weight?	Yes	No	Anemia?	Yes	No	Failure to thrive?	Yes	No
Ear Infections? Approximate number of times:	Yes	No	High birth weight?	Yes	No	Irregular heart beat?	Yes	No	Urinary tract infections?	Yes	No

SURGICAL HISTORY

Please list the date and type of any surgeries your child may have had:

Patient Name: _____

Birth Date: _____

FAMILY HISTORY

Please place a check mark under each disease that pertains to each family member.

Please add any additional diseases or relatives as needed to "Add:"

Relationship	Alive?		Age at death	Arthritis	Lung DZ	Genetic	Cancer	Psychiatry	Diabetes	Heart DZ	Hypertension	Hyperlipidemia	Stroke	Alcohol/Drug	Add:	Add:
	Yes	No														
Mother	Yes	No														
Father	Yes	No														
Sister	Yes	No														
Brother	Yes	No														
Maternal Aunt	Yes	No														
Maternal Uncle	Yes	No														
Paternal Aunt	Yes	No														
Paternal Uncle	Yes	No														
Maternal GM	Yes	No														
Maternal GF	Yes	No														
Paternal GM	Yes	No														
Paternal GF	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? Yes No

If yes please explain:

Mother's age at child's birth: _____

Mother's health during pregnancy:

Bleeding	Nausea	Physical or emotional trauma
Illness	Hypertension	Cigarettes, alcohol, drug use
Medications	Diabetes	Thyroid problems

SOCIAL HISTORY

Please list the number and relationship of persons living in the home: _____

Is your child exposed to second hand smoke? _____

Please list the number and type of pets: _____

Is there a history of sexual, mental/emotional, physical abuse? _____

If so, at what age and by whom? _____

Childs sleep patterns: _____

Age began sitting: _____ Crawling _____ Walking: _____ Talking: _____

DIET

Please describe your child's typical daily diet: _____ Referred to WIC: Yes No

Breakfast: _____ Lunch: _____ Snacks: _____

Dinner: _____ Drinks: _____

Food intolerances: _____

Breast Fed: Y/N If yes how long: _____ Formula: Y/N Type: _____

Age began solids: _____ Which foods: _____

Patient Name: _____

Birth Date: _____

IMMUNIZATIONS

Please indicate if your child has received any of the following vaccines and the dates that they were administered. administered. **Please provide a copy of your child's immunization record.**

	First	Second	Third	Fourth	Fifth	No	Yes
(Polio) OPV or IPV						No	Yes
Diphtheria, tetanus, and pertussis DtaP/DTP/DT/Td						No	Yes
(Measles, mumps, rubella) MMR						No	Yes
(Haemophilus Influenzae B) HIB MENINGITIS						No	Yes
HEPATITIS B							
HEPATITIS A							
(Chickenpox) VARICELLA						No	Yes
(Tuberculosis) TB						No	Yes
(Human Papilloma Virus) HPV						No	Yes
Influenza FLU						No	Yes
(Pneumococcal) PCV						No	Yes
(Meningococcal) MCV						No	Yes
Rotavirus							

Has your child ever experienced an adverse reaction to any immunizations? If so, please explain:

BIRTH HISTORY

Birth Length: _____ Birth Weight: _____ Gestational age: _____

Type of delivery: _____ Premature Full term Late

Hospital where your child was born: _____ Duration of labor: _____

Did your child have any of the following problems shortly after birth? (circle all that apply)

Rashes	Birth injuries	Cerebral Palsy
Jaundice	Seizures	Birth defects
Colic	Fever	Breech
Other: _____	Blue baby	