



Patient Name: _____

DOB: _____

Date: _____

Allergies: (Include Drug, Reaction, and Age of Onset):

Current Problems:

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____
 Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: Vaginal C-Section
 Duration of Labor: _____ If C-Section why? _____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
 Infant Feeding : Breast Bottle Both Formula Name? _____

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: _____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD _____	Yes	No	Allergic Rhinitis _____	Yes	No
Anemia _____	Yes	No	Asthma _____	Yes	No
Congenital Heart Disease _____	Yes	No	Constipation _____	Yes	No
Developmental Delay _____	Yes	No	Diabetes _____	Yes	No
Eczema _____	Yes	No	Food Allergies _____	Yes	No
GE Reflux _____	Yes	No	Murmur _____	Yes	No
Prematurity _____	Yes	No	Recurrent Otitis (ear infections) _____	Yes	No
Recurrent Strep Throat _____	Yes	No	Seizures _____	Yes	No
UTI _____	Yes	No	Vision Problems _____	Yes	No
Vesicoureteral Reflux _____	Yes	No	Wheezing _____	Yes	No

Other Medical History:

Surgical History: (Check Appropriate Box)

	Date		Surgeon
Adenoidectomy (adenoids removal)	Yes	No	
Appendectomy (appendix removal)	Yes	No	
Ear Tubes	Yes	No	
Fundoplication	Yes	No	
Gastrostomy Tube Placement	Yes	No	
Heart Surgery	Yes	No	
Hernia Repair	Yes	No	
Orthopedic Surgery	Yes	No	
Tonsillectomy	Yes	No	
Urologic Surgery	Yes	No	
VP Shunt	Yes	No	

Other Surgical History:



Patient Name: _____

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Family History: (Check all boxes that apply)

Relationship to CHILD	Name	Status		Allergic Rhinitis	Anemia	Asthma	Blood Disorder	Cancer	Deafness	Diabetes	Drug Abuse	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Mental Illness	Migraines	Seizures	Sudden Death	Thyroid Disease	Tuberculosis	Other
		A: Alive	D: Deceased																			
Parents	Mother	A	D																			
	Father	A	D																			
Sibs	Sister	A	D																			
	Brother	A	D																			
Aunts/Uncles	*M Aunt	A	D																			
	*M Uncle	A	D																			
	*P Aunt	A	D																			
	*P Uncle	A	D																			
Grand-parents	*MGM	A	D																			
	*MGF	A	D																			
	*PGM	A	D																			
	*PGF	A	D																			

Comments (including other family medical problems): _____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to CHILD	Name	A	D																			
		A	D																			
		A	D																			
		A	D																			
		A	D																			
		A	D																			
		A	D																			
		A	D																			

Home Environment:

Number of People at Home: _____
 Lives with biological parents: Yes _____ No _____
 Foster Care: Yes _____ No _____
 Primary Care Givers (circle): Parents _____ Daycare _____ Relatives _____ Others: _____
 Daycare (hours/day): _____
 Time at Relatives (hours/day): _____
 Pets: Yes _____ No _____

Parent's Status:

Parent's Marital Status (circle): Married _____ Divorced _____ Single _____ Other _____
 Mother's Occupation: _____
 Father's Occupation: _____