

Patient's Name:_____ Date of Birth:_____

FAMILY HISTORY

	Date of Birth	Ht.	Wt.	Medical Problems	Educational Level
MOTHER					
FATHER					

Is there a family history of any of the following (please include the child's parents, siblings, grandparents, aunts and uncles)?

Please check yes or no to all questions.

Diabetes	☐ Yes ☐ No	Bleeding Tendencies	☐ Yes ☐ No
Asthma / Wheezing	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Early Heart Attacks	☐ Yes ☐ No
Mental Problems	☐ Yes ☐ No	Other Heart Disease	☐ Yes ☐ No
Emotional Problems	☐ Yes ☐ No	Hip Disorders in Infancy	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Birth Defects	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Other Illnesses	☐ Yes ☐ No		

If you answered yes to any of the above questions above, please explain: _____

SOCIAL HISTORY

- Do you and your family have a religious preference? ☐ Yes ☐ No If yes, please specify: _____
- Marital status of parents: ☐ Married ☐ Single
- Has there been a separation, divorce, or death? ☐ Yes ☐ No If yes, please specify: _____
- Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine? ☐ Yes ☐ No If yes, please specify: _____
- Is there a gun in your home? ☐ Yes ☐ No
- Are there pets in your home? ☐ Yes ☐ No
- Does anyone in your home smoke? ☐ Yes ☐ No
- Are there financial problems in the family? ☐ Yes ☐ No
- Are there family disagreements on how to raise this child? ☐ Yes ☐ No
- With whom does the patient live? (List all household members and their relationship to the patient.)

PREGNANCY HISTORY WITH THIS CHILD

- Have you had breast surgery? ☐ Yes ☐ No
- Did you take hormones during pregnancy? ☐ Yes ☐ No
- Did you take any drugs during pregnancy? ☐ Yes ☐ No
- Did you smoke during pregnancy? ☐ Yes ☐ No
- Did you drink any alcoholic beverages during pregnancy? ☐ Yes ☐ No
- Has the child's mother had any miscarriages, stillbirths, or abortions? ☐ Yes ☐ No If yes, please list:

BIRTH HISTORY OF CHILD

- Full term pregnancy? ☐ Yes ☐ No Premature Birth? ☐ Yes ☐ No If yes, how many weeks? _____
- Adopted? ☐ Yes ☐ No If yes, at what age? _____ Has the child been told they are adopted? ☐ Yes ☐ No
- Where was your child born? _____ Obstetrician: _____
- Birth Weight: _____ Length: _____ Head Cir: _____ Apgars: _____
- Breast fed ☐ Yes ☐ No Bottle fed ☐ Yes ☐ No
- Any problems at birth? ☐ Yes ☐ No If yes, please specify: _____

CHILD'S DEVELOPMENT

Please list age of child when the following milestones were reached:

Sat alone at _____ mos.	Walked at _____ mos.	Words at _____ mos.	Sentences at _____ mos.
First teeth at _____ mos.	Bowel trained at _____ mos.	Bladder trained at _____ mos.	

Does the child have any handicap? ☐ Yes ☐ No If yes, please specify: _____

SCHOOL PERFORMANCE

Scholastic performance:

- Academic: _____
- Behavior: _____

Has your child ever been in a special education class? ☐ Yes ☐ No

Has your child had a learning problem? ☐ Yes ☐ No If yes, please specify: _____

PAST ILLNESSES

Please mark the date or frequency of illness or specify substance causing allergy.

Roseola		Asthma		Rubella (German Measles)	
Chicken Pox		Heart Murmur		Allergic to Medication	
Mumps		Colds		Allergic to Foods	
Tonsillitis		Scarlet Fever		Allergic to Insect Bites	
Pneumonia		Ear Infections		Has patient received desensitization shots?	☐ Yes ☐ No
Convulsions		Urinary Infections		Other	

OPERATIONS AND HOSPITALIZATIONS

Please specify the date or reason:

Appendectomy		Tonsils and Adenoids		Ear Tubes	
Other Operations:					
Other Hospitalizations:					

MEDICATIONS

Is your child taking any medication on a regular basis? ☐ Yes ☐ No If yes, please specify: _____

CHILD'S PREVIOUS PEDIATRICIAN

Name: _____ Phone #: (_____) _____

ANYTHING ELSE ABOUT YOUR CHILD?

Is there anything else about your child you feel we need to know to provide the best medical care for him / her?

Physician's Signature: _____