Child's Name_____ Date of Birth_____ Today's Date_____

Past Medical History

Check all that apply

	ADD		Glasses/ Contacts		History of strep throat
	ADHD		Heart Murmur/Heart Problems		Serious injuries
	Anemia		Thyroid disease		Hospitalizations
	Asthma		Chickenpox		Surgeries, specify:
	Diabetes		Bed wetting after age 5		Allergies, specify:
	Eczema		Frequent ear infections		Mental health, specify:
	Seizures		Frequent UTI		Other:

Onset of menses _____ Concerns _____

Social History

Who lives at home _____

Number of Siblings _____

Smoking in the home _____

Pets _____

Guns in the home _____ If yes, are they kept locked and separate from the ammunition _____

City Water or Well Water _____

Family History

LIST THE FAMILY MEMBER(S) IT PERTAINS TO IN RELATION TO THE PATIENT

	Mother's Side	Father's Side
Asthma		
Heart Disease		
Hypertension		
Diabetes		
Thyroid Disease		
Cancer, Type		
Mental Illness		
Other:		
Other:		