

Reviewed By: _____ Date: _____

PATIENT HISTORY

NAME _____ Male ☐ Female ☐
First *Middle* *Last* Race _____
Name child is called by _____ Birthdate _____
Where was the child born? _____ Obstetrician _____
Is child adopted? _____ At what age? _____ Is child aware? _____
Full term pregnancy? _____ Premature? _____ Type of delivery? _____
Mother: Have you had breast surgery? _____
Did you take hormones or medicines during pregnancy? _____
Do you or the father have any history of S.T.D. (herpes, HIV, group B strep, etc.)? _____
Problems at birth or in first few weeks? _____
Birth wt. _____ Length _____ Head Circ. _____ Apgar _____
Is your child taking medication now? _____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY

Rubella (German measles) _____	Any orthopedic (bone, joint, muscle) problems? _____
Chicken pox Disease _____ Vaccine _____	School Problems / Performance:
Strep Throats _____ Ear infections _____	Scholastic _____
Pneumonia _____	Conduct _____
Convulsions / Seizures _____	Has child had a learning problem? _____
Urinary infections _____	Has child had a special class? _____
Bedwetting/soiling problem after age 5? _____	Disabilities? _____
Asthma _____	Any other past illnesses? _____
Allergic to any medication? _____	
Allergic to any food or insects? _____	OPERATIONS/HOSPITALIZATIONS (Include dates)
Any smokers at home? _____ Any pets? _____	Circumcision _____
Is he/she receiving allergy shots? _____	Tonsils and Adenoids _____
Heart disease? _____ A heart murmur? _____	Appendectomy _____
Meningitis? _____	Ear Tubes _____
Has child received blood transfusions or blood products? _____	Other operation or hospitalization _____

FAMILY HISTORY

	BIRTH DATE	HT.	WT.	EDUCATION LEVEL
MOTHER				
FATHER				

Has there been a separation, divorce or death? _____ When? _____
Who is legal guardian? _____ With whom does child live? _____
Has there been a remarriage? _____ What has been the attitude of your child to the situation? _____