**CHILD’S NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF VISIT:­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSON COMPLETING FORM/RELATIONSHIP:**­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PROVIDER:­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNED SEX AT BIRTH:** \_\_ Male \_\_ Female **IDENTIFY AS:** \_\_ Male \_\_ Female

**MEDICATIONS:** List all prescription, non-prescription medications and vitamins.

Medication/Other Dose How many times a day

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES:** List all allergies to medications, foods and/or other agents.

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**CHILD’S HEALTH HISTORY:** Mark the following medical issues or conditions that the child has experienced.

\_\_ Fainting Spells/Dizziness \_\_ Depression \_\_ Reflux \_\_ Palpitations

\_\_ Seizures \_\_ Suicide Attempt \_\_ Abdominal Pain \_\_ Bleeding/Clotting Issues

­\_\_ Fatigue/Weakness \_\_ ADHD \_\_ Anemia \_\_ Colic

\_\_ Broken Bones \_\_ Anxiety \_\_ Shortness of Breath \_\_ Chest Pain

\_\_ Pain in Joints \_\_ Asthma \_\_ Skin Issues \_\_ Nausea or Vomiting

\_\_ Back Pain \_\_ Wheezing/Cough \_\_ Allergies \_\_ Vision Problems

\_\_ Headaches \_\_ Kidney Stones \_\_ Hearing Problems \_\_ Repeated Infections/Colds

\_\_ Scoliosis \_\_ Constipation \_\_ Chronic Ear Infections \_\_ Problems with Teeth

\_\_ Weight Issues ­­\_\_ Diarrhea \_\_ Thyroid Problems \_\_ Sinus Problems

\_\_ Mental Health Issues \_\_ Bood in Stool/Urine \_\_ Diabetes/Increased Thirst \_\_ Other

If yes to any above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hospitalization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH HISTORY:**

**Birth weight**: \_\_\_\_\_\_\_\_lbs. \_\_\_\_\_\_\_oz/ \_\_\_\_\_\_\_\_\_kg. **Length:** \_\_\_\_\_\_\_\_\_in. **Pre-Term:** \_\_ Yes \_\_ No **Weeks Gestation:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Complications in Labor/Delivery?**  \_\_\_Yes \_\_\_No If yes, Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivery:** \_\_ Vaginal \_\_ Caesarean Section (\_\_\_Scheduled \_\_\_Emergency) **How long did baby stay in hospital after birth?** \_\_\_\_\_\_\_\_\_\_\_

**During pregnancy did the Mother: Have medical problems?** \_\_ Yes \_\_ No **Smoke? ­**\_\_Yes \_\_No

**Use medication?** \_\_ Yes \_\_ No **Use alcohol?** \_\_Yes \_\_ No **Use any drugs?** \_\_ Yes \_\_ No

If yes to any above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:** Please list patient’s family and household members:

Name: Age: Relationship: Occupation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parents are: ­­**\_\_\_\_ Married \_\_\_\_ Living together \_\_\_\_Separated \_\_\_\_ Divorced

If divorced: Who is the custodial parent?­­­­\_\_\_\_\_\_\_\_\_\_ Contact with non-custodial Parent? \_\_\_\_Yes \_\_\_\_No

**Are there pets in the home?** \_\_ Yes \_\_No If yes what type and how many: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screen time per day** (TV, video, phone, games): \_\_\_< 1 hour \_\_\_1-2 hours \_\_\_ > 2 Hours

**Outdoor time/ Exercise per day:** \_\_\_< 1 hour \_\_\_1-2 hours \_\_\_ > 2 Hours

**Exposed to second hand smoke:** \_\_\_ Yes ­­\_\_No

**FAMILY HISTORY:** Mark the following medical issues or conditions that any of your family members have experienced.

\_\_ Cancer (Type/Age) \_\_ Mental/Emotional Issues \_\_ Diabetes \_Type 1 \_ Type 2

­­\_\_ High Cholesterol \_\_ Depression \_\_ Arthritis

\_\_ High Blood Pressure \_\_ Anxiety \_\_ Asthma

\_\_ Heart Disease (Death <50 yrs. old) \_\_ Alcoholism \_\_Allergies

\_\_ Bleeding/Clotting Issues \_\_ Drug Addiction \_\_ Sickle Cell

\_\_ Seizures \_\_ Thyroid Abnormalities \_\_ Other­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes to any above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

Do you have any concerns about the following:

**Physical Development?** \_\_ Yes \_\_ No **Mental Development?** \_\_ Yes \_\_ No **Emotional Development?** \_\_ Yes \_\_ No

**Behavior Problems?** \_\_ Yes \_\_ No **Eating Habits?** \_\_ Yes \_\_ No **Sleeping Habits?** \_\_ Yes \_\_ No

**School Experience?** \_\_ Yes \_\_ No **Bathroom/Toilet Habits?** \_\_ Yes \_\_ No **Concentration?** \_\_ Yes \_\_ No

**Sitting/Standing/Crawling/Walking?** \_\_ Yes \_\_ No **Issues in Social settings?** \_\_ Yes \_\_ No Other: \_\_\_\_\_\_\_\_\_\_\_\_

 **Other**:­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Girls only: Age of first period?** \_\_\_\_\_ **Are they regular?**  \_\_ Yes \_\_ No **Concerns?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_ Friends \_\_ Family \_\_ Print Ad \_\_ Online Ad \_\_ Online Search \_\_ Radio \_\_

 \_\_\_ We have been part of the Buttermilk Falls Pediatrics family for a long time

 THANK YOU FOR SPENDING THE TIME TO COMPLETE THIS FORM