Flanders Pediatrics, LLC

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RETURNING PATIENTS

Child's Name: _____ **Date of Birth:** _____

CURRENT MEDICATIONS: (Please include Over the Counter, Herbal and Nutritional Supplements):_____

PAST MEDICAL HISTORY ***Please indicate any changes to the patients' family history since last visit.***

FAMILY HISTORY (If positive, give relationship to child-**M, F, S, B, MGM, MGF, PGM, PGF**):

__ ADD/ADHD
__ Alcohol/Substance Abuse
__ Allergies
__ Anemia
__ Asthma
__ Birth defects
__ Bleeding/ Blood Disorders
__ Bone/Joint Disorders
__ Cancer
__ Cholesterol Elevation
__Cystic Fibrosis
__ Diabetes
__ Down Syndrome
__ Epilepsy/Seizures
__ Hearing Loss
__ Heart Attack < 55yrs male ___
< 65 yrs female ___
__ Heart Disease
__ High Blood Pressure
__ Infant Death
__ Kidney Disease/UTI
__ Learning/ School Difficulties
__ Mental Illness
__ Mental Retardation
__ Migraine Headaches
__ Nerve/Muscle Disorders
__ Obesity
__ Osteoporosis
__ Skin Disorders
__ Stroke
__ Sudden Death
__ Thyroid Disease
__ Tuberculosis
__ Other

SOCIAL HISTORY

Diet restrictions:
Caffeinated drinks:(circle) **Daily, Occasional, None**
Exercise level:(circle) **Daily, Occasional, None**
Sporting activities:
Parents' marital status:
Child lives with:
Animals: **Y N** Type:_____
Smoke exposure: **Y N**
Smoke/CO Detectors in home: **Y N**
Seatbelt/Car seat used routinely: **Y N**
Sunscreen used routinely: **Y N**
Insect repellent used routinely: **Y N**
Guns present in home: **Y N**
Years in school: School name:_____
Pool at home: **Y N**
Parent(s) Occupation: **(please indicate which parent)**
_____
Parents born in foreign country: **Y N**
If yes, name of country:_____

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