ALL STAR PEDIATRICS, PC
6410 JOLIET ROAD, SUITE 201
COUNTRYSIDE, IL 60525
708-352-4448

Child's Name: ____________________________ Date of Birth: _________________________

Household – Social History:

Parents Marital Status: Single Married Widowed Divorced Separated
Any Former Marriages: Father – Yes/No Mother Yes/No

Please list all those living in the child's home:

Name	Relationship To child	Age	Step siblings or half siblings not living with them

Have any of your children died: _______________________
If mother and father are not living together or if child does not live with parents, what is the child's custody status:
____.

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home:____.

Do you have any pets at the home? Yes/No Explain: ________________________________
Are there any smokers in the home: Yes/No Explain if Yes____________________________
Are there any guns in the home? Unarmed, Locked? Yes/No Explain _________________________________

Birth History:

Birth Place: ____________________________ Birth Weight: __________ Apgar Score: _____________________
Please circle any that apply: Natural conception, IVF, egg donor, sperm donor, adopted, Other ________________
Please circle: Was the delivery Vaginal or Cesarean? If cesarean why? ___________________________________
Please circle: Was the baby born Full Term? Or early? If early how many weeks' gestation: ________________
Did your baby have any problems right after birth: Yes/No Explain:__________________________________
Please circle: Did you breastfeed or bottle feed? ____
Did your baby go home with mother from the Hospital? Yes/No Explain __________________________________
During pregnancy, did mother Smoke? Yes/No Drink Alcohol? Yes/No
During pregnancy, did mother use drugs or medications? Yes No. – What/When ___________________________

General:

Are your child's immunizations up to date? Yes/No If No Explain ____________________________
Are you concerned about your child's health? Yes/No If Yes Explain____________________________
Is your child allergic to any medicines or drugs? Yes/No If Yes Explain____________________________
In times of stress, do you have support available? Yes/No

Development:

Have there been any developmental delays?
Physical? ____________________ Speech? ___________________________ Fine Motor ?____________________
Are you concerned about your child's mental or emotional development? Yes/No Explain_____________________

Past Medical History:

Does your child have or has he/she ever had the following?

Condition	Response
Serious injuries or accident:	Yes/No Explain:________________
Surgeries (date, type)	Yes/No Explain:________________
Hospitalizations (date, reason)	Yes/No Explain:________________
Chickenpox	Yes/No Explain:________________
Frequent ear or sinus infections	Yes/No Explain:________________
Frequent pharyngitis/tonsillitis	Yes/No Explain:________________
Other infectious diseases	Yes/No Explain:________________
Allergic Rhinitis	Yes/No Explain:________________
Allergies to animals	Yes/No Explain:________________
Outdoor allergens	Yes/No Explain:________________
Indoor allergens	Yes/No Explain:________________
Lung Problems (wheezing/asthma/pneumonia)	Yes/No Explain:________________
Heart problems (murmur)	Yes/No Explain:________________
Frequent abdominal pain	Yes/No Explain:________________
Constipation requiring doctor visit	Yes/No Explain:________________
Reflux	Yes/No Explain:________________
Urinary tract infections	Yes/No Explain:________________
Bedwetting (after 6 yrs. Old)	Yes/No Explain:________________
Eye conditions/corrective lenses	Yes/No Explain:________________
Problems with ears/hearing	Yes/No Explain:________________
Any chronic skin problems (acne/eczema)	Yes/No Explain:________________
Anemia or bleeding problems	Yes/No Explain:________________
Blood transfusions	Yes/No Explain:________________
Frequent headaches	Yes/No Explain:________________
Convulsions/Seizures	Yes/No Explain:________________
ADHD/ADD	Yes/No Explain:________________
Orthopedic problems	Yes/No Explain:________________
Diabetes	Yes/No Explain:________________
Endocrine problems	Yes/No Explain:________________
(Girls)Has she started her menstrual period	Yes/No Explain:________________
(Girls)Are there problems with her period	Yes/No Explain:________________
Use of alcohol or drugs	Yes/No Explain:________________
Emotional problems	Yes/No Explain:________________

Any other comments: ________________________________