

Cactus Children's Clinic, PC
5940 W. Union Hills Drive, D100
Glendale, AZ 85308

Patient Name: _____ **DOB:** _____

PATIENT HISTORY

During your pregnancy did you: (answer 1 – 9 if child is less than 2 yrs old)

1. Have an illness? _____
2. Take any medications? _____
3. Deliver prematurely or at term? _____
4. Were you positive for Group B Strep? _____

Did your baby:

5. Have any trouble starting to breathe? _____
6. Have any particular trouble while in the hospital? _____
7. Have jaundice? _____
8. What was the birth weight? _____
9. Was the delivery by c-section or vaginal? _____

Feeding & Digestion:

10. Were there any unusual feeding problems or severe colic the first three months? _____
11. Is your child's appetite usually good? _____
12. Is it good now? _____
13. Do any foods disagree with him/her? _____
14. Does she/he often have diarrhea or vomiting? _____
15. Has constipation ever been much of a problem? _____
16. Does she/he take vitamins? _____
17. If still on formula, which one do you use? _____

Family History

Has any blood relative of your child ever had or been treated for: (circle one)

If yes, please list family member who has been treated:

Allergies	YES	NO	_____
Asthma	YES	NO	_____
Blood disease/bleeding problem.	YES	NO	_____
Cancer	YES	NO	_____
Lung Disease	YES	NO	_____
Seizures/Epilepsy	YES	NO	_____
Heart trouble (before age 55)	YES	NO	_____

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Diabetes	YES	NO	_____
Tuberculosis (T.B.)	YES	NO	_____
Mental Illness	YES	NO	_____
Hepatitis B or C carrier	YES	NO	_____

Social/Developmental History

1. Child has how many sisters? _____ brothers? _____
2. Who spends most time caring for child? _____ (mother, father, etc.)
3. Does child go to day care, baby sitter or preschool on a regular basis? YES NO
4. Child sat up at _____ (age)
5. Child crawled at _____ (age)
6. Child walked at _____ (age)
7. Child started talking at _____ (age)

Medical History

Has your child:

1. Had any serious illnesses, injuries or chronic disease? _____
2. Been hospitalized? If so when & for what? _____
3. Had surgery? (tonsils, hernia, etc.) _____
4. More than 3 episodes of ear infections in the same year? _____
5. Have allergies to medications, food or other allergens? _____
6. Take daily or regular medication? _____
7. Do you have Immunization Records we can copy? YES NO
8. Has your child had chicken pox, the illness? YES NO Date: ____/____/____

Signature of parent of legal guardian _____

Reviewed by: _____