Patient's Name: ____ Date of Birth:____________________________

FAMILY HISTORY

	Date of Birth	Ht.	Wt.	Medical Problems	Educational Level
MOTHER					
FATHER					

Is there a family history of any of the following (include child's parents, siblings, grandparents, aunts and uncles)?

Please check yes or no to all questions.

Diabetes	☐ Yes ☐ No	Bleeding Tendencies	☐ Yes ☐ No
Asthma / Wheezing	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Early Heart Attacks	☐ Yes ☐ No
Mental Problems	☐ Yes ☐ No	Other Heart Disease	☐ Yes ☐ No
Emotional Problems	☐ Yes ☐ No	Hip Disorders in Infancy	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Birth Defects	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Other Illnesses	☐ Yes ☐ No		

If you answered yes to any of the above questions above, please explain: ____

SOCIAL HISTORY

- Do you and your family have a religious preference? ☐ Yes ☐ No If yes, please specify: ___________
- Marital status of parents: ☐ Married ☐ Single
- Has there been a separation, divorce, or death? ☐ Yes ☐ No If yes, please specify: ______________________________
- Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine? ☐ Yes ☐ No
  If yes, please specify:____
- Is there a gun in your home? ☐ Yes ☐ No
- Are there pets in your home? ☐ Yes ☐ No
- Does anyone in your home smoke? ☐ Yes ☐ No
- Are there financial problems in the family? ☐ Yes ☐ No
- Are there family disagreements on how to raise this child? ☐ Yes ☐ No
- With whom does the patient live? (List all household members and their relationship to patient.)

  ____

  ____

PREGNANCY HISTORY WITH THIS CHILD

- Have you had breast surgery? ☐ Yes ☐ No
- Did you take hormones during pregnancy? ☐ Yes ☐ No
- Did you take any drugs during pregnancy? ☐ Yes ☐ No
- Did you smoke during pregnancy? ☐ Yes ☐ No
- Did you drink any alcoholic beverages during pregnancy? ☐ Yes ☐ No
- Has the child's mother had any miscarriages, stillbirths, or abortions? ☐ Yes ☐ No
  If yes, please list: ____

(Over)

BIRTH HISTORY OF CHILD

- Full term pregnancy? ☐ Yes ☐ No Premature Birth? ☐ Yes ☐ No If yes, how many weeks?________________
- Adopted? ☐ Yes ☐ No If yes, at what age? __________ Has the child been told they are adopted? ☐ Yes ☐ No
- Where was child born? ____________________________________ Obstetrician:____
- Birth Weight:_____________Length:____________ Head Cir:____________ Apgars:____________
- Breast fed ☐ Yes ☐ No Bottle fed ☐ Yes ☐ No
- Any problems at birth? ☐ Yes ☐ No If yes, please specify:____

CHILD'S DEVELOPMENT

Please list age of child when the following milestones were reached:

Sat alone at _________ mos. Walked at _________ mos. Words at _________ mos. Sentences at ________ mos.

First teeth at ________ mos. Bowel trained at ________ mos. Bladder trained at ________ mos.

Does the child have any handicap? ☐ Yes ☐ No If yes, please specify:____
Is there a bed-wetting problem? ☐ Yes ☐ No Is there a family history of bedwetting? ☐ Yes ☐ No

SCHOOL PERFORMANCE

Scholastic performance:

- Academic:____
- Behavior:____

Has child ever been in a special education class? ☐ Yes ☐ No
Has the child had a learning problem? ☐ Yes ☐ No If yes, please specify::____

PAST ILLNESSES

Please mark date or frequency of illness or specify substance causing allergy.

Roseola		Asthma		Rubella (German Measles)	
Chicken Pox		Heart Murmur		Allergic to Medication	
Mumps		Colds		Allergic to Foods	
Tonsillitis		Scarlet Fever		Allergic to Insect Bites	
Pneumonia		Ear Infections		Has child received desensitization shots?	☐ Yes ☐ No
Convulsions		Urinary Infections		Other	

OPERATIONS AND HOSPITALIZATIONS

Please specify date or reason.

Appendectomy		Tonsils and Adenoids		Ear Tubes	
Other Operations:					
Other Hospitalizations:					

MEDICATIONS

Is your child taking any medication on a regular basis? ☐ Yes ☐ No If yes, please specify::____

CHILD'S PREVIOUS PEDIATRICIAN

Name:____ Phone #: (_________)______________________________

ANYTHING ELSE ABOUT YOUR CHILD?

Is there anything else about your child you feel we need to know to provide the best medical care for him / her?

____

Name of person completing this form:____