Name: ____________________________________
Date of Birth: _____/_____/_____
AKA (nickname): ____________________________
Today's Date: _____/_____/_____

BIRTH HISTORY

Place of Birth ________________________________
Birth Weight ________________________________
Problems at Birth ☐ N ☐ Y________________________
____
____
Number of days in the hospital #_____________
Premature? ☐ N ☐ Y If so, how much? ____________

MEDICAL HISTORY

Hospitalizations ☐ N ☐ Y

- Why? ______________________________
  When? ______________________________
  Where? ______________________________
- Why? ______________________________
  When? ______________________________
  Where? ______________________________

Surgeries ☐ N ☐ Y

- Type of surgery? ______________________
  When? ______________________________
  Where? ______________________________
- Type of surgery? ______________________
  When? ______________________________
  Where? ______________________________

Allergies to Medications ☐ N ☐ Y

Medication Reaction
______________ ____________________
______________ ____________________
______________ ____________________

Environment/Food Allergies ☐ N ☐ Y

Allergy Reaction
______________ ____________________
______________ ____________________
______________ ____________________

Health Conditions (When diagnosed/Specialist Name)

☐ Asthma ____________________
☐ Wheezing ____________________
☐ Pneumonia ____________________
☐ Ear Infections ____________________
☐ ENT Disorders ____________________
☐ Hearing Problems ____________________
☐ Vision Problems ____________________
☐ Gastrointestinal Disorder ____________________
☐ Bladder/Urine Infections ____________________
☐ Fractures ____________________
☐ Behavior Problems ____________________
☐ Developmental Concerns ____________________
☐ Other ____________________________________

MEDICATIONS Prescribed and over-the-counter. Include vitamins, herbs, and home remedies.

MEDICATION	DOSE	TIMES PER DAY

IMMUNIZATION HISTORY

Please provide us with a copy of your child's immunization record prior to your appointment. If you do not have a copy, please call us so that we can assist you in obtaining these records. At the time of your visit, you will be asked to sign a record release so that we may obtain these records. You will need to provide us with the name and/or location of the facility at which we can request records.

Has your child been seen by any other healthcare provider from whom we should request records?
☐ N ☐ Y Who? ______________________________

Name ____________________________________
MRN ____________________________________

MOTHER'S PREGNANCY HISTORY

Prenatal Care ☐ N ☐ Y Where/Name of Provider ______________________________

Any medical problems during your pregnancy? ☐ N ☐ Y If so, please list: ______________________

____

List medications taken during pregnancy, both for the pregnancy and routine as prescribed by your doctor. Include vitamins, herbs, and home remedies.

MEDICATION	DOSE	TIMES PER DAY

Tobacco Use During Pregnancy: ☐ Never

☐ Cigarettes ☐ Packs/day _________ ☐ Other ____________________

Alcohol Intake During Pregnancy: ☐ Yes ☐ No ☐ Drinks/wk__________

Is alcohol a concern for you/others? ☐Y ☐N

Drug Use During Pregnancy:

Non-legalized drugs? ☐Y ☐N What Kind? ______________________________

FAMILY HISTORY OF CHILD

FAMILY HISTORY Check all that apply	**AGE**	Mental health disorder	ADHD/ Learning Disorders	Alcohol/Drug abuse	Cancer	Leukemia	Diabetes	High Blood Pressure	High Cholesterol	Respiratory disorder	Heart disease	Birth defects	Seizure disorder	Cause of Death
Father														
Mother														
Maternal Grandfather														
Maternal Grandmother														
Paternal Grandfather														
Paternal Grandmother														
Brothers														
Sisters														

Does your child spend time with a parent that is not living in the household? ☐ Yes ☐ No

Please explain: ____

Please list all people living in your child's household: ______________________________

____

What are your current concerns? ____

____

Name ______________________________

MRN ______________________________