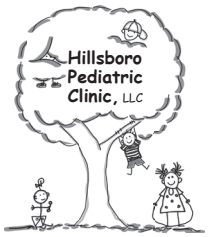
Patient History



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

Please answer the following questions about your baby's/child's medical and family history.
The physician may ask further details about "yes" answers.

PREGNANCY AND BIRTH: **Yes** **No**

Were there any problems with pregnancy or delivery of this child? _____ _____
If yes, please explain: _____
Was baby full-term _____ or early? _____ If early, how many weeks? _____
Was your child breastfed? No _____ Yes _____ If so, for how long? _____
Type of Delivery: Vaginal _____ C-section _____ Length _____ Weight _____

Problems:	**Yes**	**No**		**Yes**	**No**
Jaundice	_____	_____	Breech	_____	_____
Respiratory Distress	_____	_____	Developmental Problems	_____	_____
Feeding Problems	_____	_____	If yes, please explain: _____		
Rash	_____	_____	_____		

HOSPITALIZATIONS/OPERATIONS:

❑ NONE

Hospital Reason Year

_____
_____
_____
_____

MEDICATIONS AND DOSAGES (Please include over-the-counter, supplements, homeopathic and prescribed medications):

❑ NONE

_____
_____
_____
_____

ALLERGIES TO ANY MEDICATIONS? (Please list)

❑ NONE KNOWN

_____
_____
_____
_____

DOES YOUR CHILD SEE ANY SPECIALISTS? (Nutritionist; Occupational, Physical and/or Speech Therapist; Counselor; or other medical specialists)

❑ NONE

Name of Specialist Reason

_____
_____
_____

SOCIAL AND ENVIRONMENTAL HISTORY **Yes** **No**

How many hours of exercise does your child get per day? _____

Does your child spend more than 2 hours per day watching TV, playing video games, or on the computer?	_____	_____
Does anyone living in the home smoke?	_____	_____
Does anyone living in the home drink alcohol?	_____	_____
Are there smoke detectors in the home?	_____	_____
Seat belts used in your car?	_____	_____
Is your child in school or day care?	_____	_____
Does your child wear a bike helmet while riding?	_____	_____
Are there guns in your home?	_____	_____
Do you have the poison-control center phone number near your telephone?	_____	_____

MEDICAL HISTORY (Check if your child/children has had any of the following):

Asthma	_____	Epilepsy	_____
Anemia	_____	Eye or vision problems	_____
Chicken Pox	_____	Kidney/Bladder problems	_____
Diabetes	_____	Liver disease/Jaundice	_____
Chronic diarrhea/constipation	_____	Tuberculosis	_____
Ear problems	_____	Other - Please explain	_____
Eczema (overly dry skin)	_____	_____	

(OVER)

Please List Patient's Biological Parents:

Mother: _____ DOB: _____

Father: _____ DOB: _____

Does Patient live with Biological Parents? (Circle one) YES NO
If **No,** please indicate name of person patient is living with and relationship below:

Name: _____ Relationship to Patient: _____

FAMILY MEDICAL HISTORY (Please fill out the following based only on biological family members of the patient)
❑ CHECK HERE IF NONE OF THE CONDITIONS BELOW APPLY TO ANY BIOLOGICAL FAMILY MEMBERS

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other
ADD/ADHD						
Allergies						
Asthma						
Birth Defects						
Cancer						
Heart Problems						
Hip Problems						
Deafness						
Depression						
Developmental Delay						
Diabetes						
Eczema						
Genetic Disorder						
Blood Disorder						
High Cholesterol						
High Blood Pressure						
Learning Disability						
Mental Retardation						
Migraines						
Obesity						
Curved Spine						
Seizure Disorder						
Sudden Infant Death						
Crossed Eyes						
Thyroid Disease						
Hepatitis						
Tuberculosis						
Other:						

Signature **Print Name** **Relationship to Patient** **Date**