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

Patient History

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
Where 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? ☐ YES ☐ NO 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?	☐	☐
If yes, are the guns safely stored (i.e. Locked in a gun safe)?	☐	☐
Do you have the poison-control center phone number near your telephone?	☐	☐

Medical History (Check if your baby/child 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)	☐	_____	

MORE ON BACK

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

Please List Patient's Biological Parents:

Mother: _____ DOB: _____

Father: _____ DOB: _____

Does Patient live with Biological Parents? (Check 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	☐	☐	☐	☐	☐	
Intellectual Disability	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	☐	
Curved Spine	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	
Sudden Infant Death	☐	☐	☐	☐	☐	
Crossed Eyes	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

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