Child’s Name M F Date

Date of Birth Age Patient ID #

Parent (1) Name E-mail

Phone: H ( ) C ( ) W ( )

Address - Street City ST Zip

Parent (2) Name E-mail

Phone: H ( ) C ( ) W ( )

Address - Street City ST Zip

Child’s School Grade

Previous Physician City/State Phone: ( )

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Allergies** | | |  | **Medications** | | |
| **Substance** |  | **Reaction** |  | **Medication Name** |  | **Dosage** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Anemia * Asthma * Bronchitis/Bronchiolitis * Bronchopulmonary Dysplasia (BPD) * Chicken Pox * Hepatitis * Immune Deficiency/HIV * Measles (10-day) * Measles Rubella (3-day) * Mumps * Prematurity * Rheumatic Fever * Pneumonia * Sickle Cell Disease * Whooping Cough * Other   **GENERAL**   * Chills * Depression * Dizziness * Fainting * Forgetfulness * Headache * Loss of sleep * Mood swings * Nervousness * Numbness * Sweating * Tiredness * Weight loss/gain | **RESPIRATORY**   * Asthma * Pneumothorax (Collapsed lung) * Chronic Sinsitis * Emphysema * Bronchitis * Upper Respiratory Condition   **NOSE/THROAT/CHEST**   * Difficulty breathing * Difficulty swallowing * Frequent colds * Hoarseness * Mouth-breathing * Nosebleeds * Persistent cough * Sinus problems * Sore throats * Strep Throat * Tonsil infections * Wheezing   **HEARING/SPEECH**   * Difficulty hearing * Earache * Ear infections * Hoarseness * Ear Surgery   Speech problems: \_\_ | **CARDIOVASCULAR**   * Breathing problems * Chest pain * Irregular heart beat   **GASTROINTESTINAL**   * Appetite poor * Bloody or dark stools * Constipation * Diarrhea * Excessive hunger * Excessive thirst * Nausea * Rectal bleeding * Stomachaches * Vomiting * Worms   **EYES**   * Crossed or wandering eyes * Eye irritation * Headaches * Vision problems   **DENTAL**   * Bleeding gums * Grinding teeth * Sensitivity to hot/cold * Thumb-sucking * Last dental check-up   Date   * Brush, how often? * Floss, how often? | **MUSCLE/JOINT/BONE**   * Broken bones or sprains * Coordination problems * Pain, weakness, swelling in:  |  |  | | --- | --- | | * Arms * Back * Feet * Hands | * Hips * Legs * Neck * Shoulders |   **GENITO-URINARY**   * Bed-wetting * Blood in urine * Diaper rash, persistent * Discharge from vagina or penis * Frequent urination * Painful urination * Unusual urine odor   **SKIN**   * Bruise easily * Change in moles * Hives * Itching * Rash * Scars * Sores that won’t heal |

Please check (√) if child has ever had any of the following:

**DIETARY ASSESSMENT**

How often does your child eat the following:

3 Times Daily Daily Weekly Monthly

Beans, peas

Breads, cereals, grains

Candy

Dairy products

Eggs

Fruits

Meats

Poultry, fish

Sodas

Vegetables, green

Vegetables, yellow

What vitamin supplements does your child take? How often?

Is there fluoride in your water? Yes No

|  |  |  |
| --- | --- | --- |
| **HOSPITALIZATIONS** |  | **INJURIES** |
| |  |  |  | | --- | --- | --- | | Reason | Date | Hospital, City, State | |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Serious Injuries/Illnesses |  | Date |  | Outcome | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   Has your child ever had a blood transfusion? Yes No |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please check √ whether or not your child has been given the following **Immunizations**. If yes, please fill in the date(s) given.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  | | --- | --- | --- | --- | | **YES** | **NO** | **DATE** |  | |  |  |  | Hepatitis B | |  |  |  | DPT, series of 3 shots | |  |  |  | DPT booster shots | |  |  |  | Hib (Influenza) | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **YES** | **NO** | | **DATE** | | |  | | |  | |  | | \_\_\_\_ | Polio shots, series of 3 | | |  | |  | | \_\_\_\_ | Polio booster shots | | |  | |  | | \_\_\_\_ | Polio by mouth series of 3 | | |  | |  | | \_\_\_\_ | Hib (Pneumococcal) | | | |  |  |  |  | | --- | --- | --- | --- | | **YES** | **NO** | DATE |  | |  |  |  | Measles Vaccine | |  |  |  | Mumps Vaccine | |  |  |  | Rubella Vaccine | |  |  |  | Chicken Pox Vaccine | | |
| **FAMILY HISTORY** |
| **Please give the following information about your child’s immediate family:**  Age General Health Age General Health   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Father |  |  | Sibling |  |  | M | F | | Mother |  |  | Sibling |  |  | M | F | | Have any of your children died? Yes No | | | Sibling |  |  | M | F | |

**Please check (√) the conditions that any of the child’s blood relatives (Including parents and siblings) have had and the relationship to the child:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition**   * Alcoholism * Allergies * Anemia * Arhtritis * Asthma/emphysema * Birth defects * Bon/joint disorders * Cancer * Diabetes * Epilepsy * Eye or ear disorders/Hearing loss/Blindness * Genetic defects * Heart disease | **Relationship**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Condition**   * HIV/AIDS * Hemophilia * High blood pressure * Kidney Disease * Lung Disease * Mental disease/disorder * Rheumatic fever * Seizures/ convulsions * Sickle cell anemia * Skin disease * Stroke * Thyroid disease * Tuberculosis * Venereal disease * Other: \_\_\_\_\_\_\_\_\_\_\_\_ | **Relationships**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PRE-NATAL AND INFANT HEALTH HISTORY** |

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Obstetrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s age at birth:\_\_\_\_

**During the pregnancy which conditions did you have? Please check (√) all that apply:**

|  |  |
| --- | --- |
| * Alcohol Use * Anemia * Diabetes * Drug use, non-prescription drugs (Please list): \_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Drug use, prescription drugs (Please list):\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Drug use, controlled drugs such as narcotics (Please list)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Edema (Swelling) | * Exposure to chemical or radiation * Fever * German measles * Hepatitis * High blood pressure * Protein in urine * Tobacco use * Urinary tract infection * Venereal disease * Other illnesses or infections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DELIVERY** Please check (√) all that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| * On time | * Premature | * Late | * Normal | * Induced | * Prolonged | * Breech | * C-Section |

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INFANT HEALTH**  Birth weight: \_\_\_\_\_\_\_\_\_\_\_ Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Discharge weight: \_\_\_\_\_\_\_\_\_\_ Age when discharged:\_\_\_\_  **INFANT HEALTH PROBLEMS** Please check (√) and describe   * Birth defects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Breathing problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Jaundice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Transfusion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **FEEDING**   * Breast Fed * Formula Fed | **DEVELOPMENTAL** Please note age at which your child:  Lifted head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wk.  Rolled over \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Cooed/ Laughed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Sat up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Stood up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Walked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Finger fed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Drank from cup \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Spoon fed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  First word \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Toilet trained \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo.  Dressed self \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mo. |

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| **EDUCATION AND SOCIAL HISTORY** |

**Please explain any problems or concerns you have about your child in any of the following areas:**

Appearance/Weight/Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Friends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grades/ learning ability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexuality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per day does your child watch television or play video games? \_\_\_\_\_\_\_\_\_\_\_\_ Get exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| * Drugs | * Alcohol | * Tobacco | * None |

Do you suspect that your child is involved with:

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information

can be dangerous to my child’s health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion

of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name of Parent, Guardian or Personal Representative Relationship to Patient

Dr. Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_