Account Number _____

Patient Name: _____ _____ **DOB:** _____/_____/_____
(First name) (Last name)

Gender: ☐ Male ☐ Female

BIRTH HISTORY

Birth Weight _____ (pounds) Length: _____(inches) Place of Birth: _____

☐ **Preterm (_____weeks) (OR)** ☐ **Full Term** ☐ **Vaginal (OR)** ☐ **C-Section**

PAST MEDICAL HISTORY

Has the child ever had any problem with the following? If yes, please explain.

Disease			If yes, please explain
ADHD	☐ NO	☐ YES	_____
Asthma	☐ NO	☐ YES	_____
Allergies (food/environmental)	☐ NO	☐ YES	_____
Allergies to medications	☐ NO	☐ YES	
Anemia/Blood Disorders	☐ NO	☐ YES	_____
Bones/Joints	☐ NO	☐ YES	_____
Diabetes	☐ NO	☐ YES	_____
Ears (multiple infections)/Hearing	☐ NO	☐ YES	_____
Eyes/Vision	☐ NO	☐ YES	_____
Constipation	☐ NO	☐ YES	_____
Diarrhea	☐ NO	☐ YES	_____
Reflux	☐ NO	☐ YES	_____
Gastrointestinal disorder	☐ NO	☐ YES	_____
Heart	☐ NO	☐ YES	_____
Repeated Infections	☐ NO	☐ YES	_____
Headaches	☐ NO	☐ YES	_____
Seizures	☐ NO	☐ YES	_____
Mental health/ Substance abuse	☐ NO	☐ YES	_____
Skin (eczema)	☐ NO	☐ YES	_____
Urine/Kidneys	☐ NO	☐ YES	_____
Tuberculosis	☐ NO	☐ YES	_____
Other			_____

Are the child's immunizations up to date: ☐ Yes ☐ No

Does your child use any tobacco products: ☐ Yes ☐ No

Does your child have any medication, food, or environmental allergies: ☐ Yes ☐ No
If yes, please list:

Allergy: Reaction:

_____ _____

_____ _____

Please list medications your child is currently taking and reason for taking. Please include over-the-counter medications:

Medication Name:	Dose:	Reason:
_____	_____	_____
_____	_____	_____

Please list any hospitalizations, operations, serious illness or injuries:

_____ **Date**: _____/_____/_____

_____ **Date**: _____/_____/_____

Please list any developmental problems /delays and when they occurred:

_____ **Date**: _____/_____/_____

_____ **Date**: _____/_____/_____

Please list other health care providers involved in patient's care:

_____ **Phone:** _____

_____ **Phone:** _____

_____ **Phone:** _____

SOCIAL HISTORY

Lives with: _____

If 2 households, Custody status: _____

Attends school/daycare at: _____ Grade:_____

Exposure to:

Smoking ☐ Yes ☐ No

Lead Paint ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Drugs ☐ Yes ☐ No

Pets ☐ Yes ☐ No

Other: _____

Has your family experienced any recent deaths within the family? ☐ Yes ☐ No

If yes, relationship to child, date, and cause of death:

_____

_____ _____

Signature Date

_____ _____

Completed by: Relationship to patient