PATIENT NAME ______________________ **DOB** ______________ **Date** ______________

Accompanied by ______________________ **Form completed by** ______________________

HOUSEHOLD

Please list all those living in the child's home

Name	Relationship to child	Date of Birth	Health Problems

Are there siblings not listed? If so, plase list their names and ages and where they live. ______________________

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent not in the home?

BIRTH HISTORY

Birth Weight ______________________

Was the baby born at term? ________ Early?________ Late?_______

If early, how many weeks gestation? ________________________

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain __________________________________

____

During pregnancy, did mother

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medication ☐ Yes ☐ No

What _____________________ When ______________________

Was the delivery ☐ vaginal ☐ cesarean

If cesarean, why? ______________________

Did your baby have problems right after birth?

☐ Yes ☐ No Explain ______________________

Was initial feeding ☐ breast? ☐ bottle?

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain ______________________

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain ______________________

Does your child have any serious medical illness or condition? ☐ Yes ☐ No Explain ______________________

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain ______________________

Has your child had any surgery? ☐ Yes ☐ No Explain ______________________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______________________

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain ______________________

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain ______________________

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain ______________________

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain ______________________

If your child is in school:

How is his/her behavior in school? ______________________

Has he/she failed or repeated a grade in school? ______________________

How is he/she doing in academic subjects? ______________________

Is he/she in special or resource classes? ______________________

REVIEWED BY ______________________ DATE ______________________

FAMILY HISTORY

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	Who ______	Comments ______
Asthma	☐ Yes	☐ No	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	Who ______	Comments ______
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High cholesterol	☐ Yes	☐ No	Who ______	Comments ______
Anemia	☐ Yes	☐ No	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	Who ______	Comments ______
Liver disease	☐ Yes	☐ No	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	Who ______	Comments ______
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
Bed wetting (after 10 years old)	☐ Yes	☐ No	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	Who ______	Comments ______
Mental illness	☐ Yes	☐ No	Who ______	Comments ______
Mental retardation	☐ Yes	☐ No	Who ______	Comments ______
Immune problems, HIV or AIDS	☐ Yes	☐ No	Who ______	Comments ______

Additional family history ______________________________

PAST HISTORY

Does your child have, or has he/she ever had:

Condition	Yes	No	Who	Comments
Chickenpox	☐ Yes	☐ No	Who ______	Comments ______
Frequent ear infections	☐ Yes	☐ No	Who ______	Comments ______
Problems with ears or hearing	☐ Yes	☐ No	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	Who ______	Comments ______
Problems with eyes or vision	☐ Yes	☐ No	Who ______	Comments ______
Asthma, bronchitis, bronchiolitis or pneumonia	☐ Yes	☐ No	Who ______	Comments ______
Any heart problem or murmur	☐ Yes	☐ No	Who ______	Comments ______
Anemia or bleeding problem	☐ Yes	☐ No	Who ______	Comments ______
Blood transfusion	☐ Yes	☐ No	Who ______	Comments ______
Frequent abdominal pain	☐ Yes	☐ No	Who ______	Comments ______
Constipation requiring doctor visits	☐ Yes	☐ No	Who ______	Comments ______
Bladder or kidney infection	☐ Yes	☐ No	Who ______	Comments ______
Bed wetting (after 5 years old)	☐ Yes	☐ No	Who ______	Comments ______
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Who ______	Comments ______
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Who ______	Comments ______
Any chronic or recurrent skin problem (acne, eczema)	☐ Yes	☐ No	Who ______	Comments ______
Frequent headaches	☐ Yes	☐ No	Who ______	Comments ______
Convulsions or other neurologic problem	☐ Yes	☐ No	Who ______	Comments ______
Diabetes	☐ Yes	☐ No	Who ______	Comments ______
Thyroid or other endocrine problem	☐ Yes	☐ No	Who ______	Comments ______
Any other significant problem	☐ Yes	☐ No	Who ______	Comments ______
Use of alcohol or drugs	☐ Yes	☐ No	Who ______	Comments ______

REVIEWED BY ______________________________ DATE ________________