Practice Site

Patient Name:______________________

DOB:______________

Date:______________

Allergies: (Include Drug, Reaction, and Age of Onset):

____

____

Current Problems:

____

____

History:

Birth History:

Birth Length: ___________ Birth Weight: _______________________ Birth Head Circumference: _____________
Discharge Weight: _______ Gestational Age at Birth (weeks): _______ Delivery Method: Vaginal C-Section
Duration of Labor: If C-Section why?____________________

APGAR 1m: ___________________ APGAR 5m: ___________________ APGAR 10m: __________________
Infant Feeding : Breast Bottle Both Formula Name? ________________

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: ____

____

Medical History: (Check Appropriate Box and Comment in Margins)

Condition			Condition		
ADD/ADHD___________________	Yes	No	Allergic Rhinitis ______________________	Yes	No
Anemia _____________________	Yes	No	Asthma ___________________________	Yes	No
Congenital Heart Disease________	Yes	No	Constipation _______________________	Yes	No
Developmental delay ___________	Yes	No	Diabetes __________________________	Yes	No
Eczema _____________________	Yes	No	Food Allergies ______________________	Yes	No
GE Reflux ___________________	Yes	No	Mental Illness ______________________	Yes	No
Murmur _____________________	Yes	No	Prematurity ________________________	Yes	No
Recurrent Otitis (ear infections) ___	Yes	No	Recurrent Strep Throat _______________	Yes	No
Seizures ____________________	Yes	No	Substance Abuse ____________________	Yes	No
UTI ________________________	Yes	No	Vision Problems _____________________	Yes	No
Vesicoureteral Reflux ___________	Yes	No	Wheezing __________________________	Yes	No

Other Medical History:

____

____

Surgical History: (Check Appropriate Box)

Procedure			Date	Surgeon
Adenoidectomy (adenoids removal)	Yes	No		
Appendectomy (appendix removal)	Yes	No		
Ear Tubes ___________________	Yes	No		
Fundoplication ________________	Yes	No		
Gastrostomy Tube Placement ____	Yes	No		
Heart Surgery_________________	Yes	No		
Hernia Repair_________________	Yes	No		
Orthopedic Surgery ____________	Yes	No		
Tonsillectomy ________________	Yes	No		
Urologic Surgery ______________	Yes	No		
VP Shunt____________________	Yes	No		

Other Surgical History:

____

____

Practice Site

Patient Name:_______________________

DOB:______________

Date:______________

Family History: (Check all boxes that apply)

Relationship to CHILD		Name	A:Alive	D:Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		A	D																		
	Father		A	D																		
Sibs	Sister		A	D																		
	Brother		A	D																		
Aunts/ Uncles	*M Aunt		A	D																		
	*M Uncle		A	D																		
	*P Aunt		A	D																		
	*P Uncle		A	D																		
Grand-parents	*MGM		A	D																		
	*MGF		A	D																		
	*PGM		A	D																		
	*PGF		A	D																		

Comments (including other family medical problems):____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to CHILD	Name																			
		A	D																	
		A	D																	
		A	D																	
		A	D																	
		A	D																	
		A	D																	
		A	D																	

Home Environment:

Number of People at Home: ______
Lives with biological parents: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others:_________________________________
Daycare (hours/day): ______
Time at Relatives (hours/day): ______
Pets: Yes No

Parent's Status:

Parent's Marital Status (circle): Married Divorced Single Other__________________________

Mother's Occupation: _________________
Father's Occupation: _________________