PATIENT NAME: **DOB:**

FAMILY MEDICAL HISTORY

Parents, do the following illnesses or conditions exist in either side of your child's family as far back as your child's grandparents?

(Please notify receptionist if you need help reading or understanding this form.)

Please answer Yes, No, or Unsure				**If yes, who had the illness?**
Illness	**Yes**	**No**	**Unsure**	***(please print legibly)***
Birth defects such as spina bifida				
Genetic problems such as Down's Syndrome				
Obesity or overweight				
Hormone exposure during pregnancy				
Alcoholism or a drinking problem				
Mental retardation				
Nervous disorders such as cerebral palsy,				
multiple sclerosis, or myesthenia gravis				
Migraine headaches				
Food allergies				
Hay fever				
Asthma				
Emphysema (affects long-term smokers)				
High blood pressure				
Heart or valve trouble such as heart attack				
Artery disease of the heart (bypass surgery)				
Tuberculosis				
Diabetes (sugar disease)				
Stroke				
AIDS or HIV positive				
Cancer				
Metabolic disease such as low calcium,				
PKU, and sugar problems other than diabetes				
Thyroid problems (underactive or goiter)				
Muscular Dystrophy				
Cystic Fibrosis				
Lung disease (e.g. legionairres disease,				
baker's lung, coal miner's lung, etc.)				
Hearing loss (deafness) at the time of birth				
Anemia (low blood)				
Hemophilia (bleeders)				
Epilepsy (convulsions, tremors, shakes)				
Hepatitis or liver disease				
Gall bladder problems				
Ulcers				
Colitis (or other intestinal problems)				
Sexually transmitted diseases (herpes, etc.)				
Kidney problems from infections				
Eye disease (cataracts, blind, nearsighted …)				
Glaucoma				
Rheumatoid arthritis				
Gout				
Rheumatic fever (heart damage possible)				

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PATIENT NAME: **DOB:**

PATIENT BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy:

1) How many of the following have you experienced:
Pregnancies ____ Miscarriages ____ Abortions ____ Children born ____
Stillbirths (babies not alive when they are born) ____
2) What was your due date with this child? _____
3) What is your blood type? _____
4) Was your blood positive for any of the following: Syphilis _____ Herpes _____
Gonorrhea _____ Hepatitis B _____
5) Were you immune to Rubella (german measles) or did you have to receive a shot for this? Immune vaccine
6) Did you have any medical problems during your pregnancy?

7) Did you take any medications? _____
8) How much weight did you gain? _____

Birth History:

Where was your child born? _____
Who delivered the baby? _____
Who was the child's pediatrician prior to coming here? _____
Was your child delivered vaginally or by C-section? _____
What was the baby's weight? _____ and length? _____
Was the baby full-term? _____ If no, how many weeks? _____ weeks
What is your child's blood type? _____
Were there any complications at the time of birth? _____
Did the baby breathe, cry, and have healthy color when born? _____
Did the baby test positive for PKU, sickle cell, or thyroid problems? _____
Was the baby circumcised? Yes No N/A

Nutrition History:

Was the baby breast-fed? _____ If yes, for how long? _____
If formula-fed, what formula? _____
Was the baby given vitamins? ____ If yes, what kind? _____
At what age did your baby eat the following soft foods?
Cereal _____ Fruit _____ Vegetables _____ Meats _____
What kind of an appetite did your baby have? _____
Did your baby have any stooling problems? _____
Did your baby have any food allergies? _____

Developmental Milestones:

Please note the approximate age at which your child accomplished the following tasks:

Held head up	_____	Smiled	_____	Sat with help	_____
Stood with help	_____	Sat alone	_____	First teeth	_____
Reached for objects	_____	Crawled	_____	Said words	_____
Spoke in sentences	_____	Stood alone	_____	Walked	_____

Current daily habits:

How many hours sleep does your child get each night? _____
Does your child nap? Yes No If yes, how long? _____
What activities does your child enjoy while at play: _____
Does your child go to school? Yes No If yes, where? _____

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PATIENT NAME: **DOB:**

PATIENT SOCIAL HISTORY

Father's Name _____ Age _____ Occupation _____

Mother's Name _____ Age _____ Occupation _____

Parents are: Married Divorced Separated Living together

Names of brothers and sisters	Gender	Age	Full-Half
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____

Total number of people living in household: _____

Check any of the following behaviors in your child that may be of concern to you:

___ Difficulty with personal relationships ___ Anxiety/nervousness ___ School Problems

___ Masturbation (playing with one's sexual organs) ___ Nail-biting ___ Thumb sucking

___ Pica (eating things such as dirt, hair, paint, etc.) ___ Breath-holding ___ Temper tantrums

Does your family eat meals together?

Do you have time to be together having fun as a family?

Do you and the children have clothing to keep you cool in summer and warm in winter?

Who does your child stay with during the day?

Do you have any pets? If yes, what kind and quantity?

Does anyone in the household smoke? If yes, where (circle)? Inside Outside Car

Does your family live in a house or an apartment (circle)? House Apartment

Do you have any problems heating or cooling the place where you live?

Do you have any problems with the water supply or the sewage system where you live?

Do the children sleep (circle): alone with each other with you

PATIENT NAME: **DOB:**

PATIENT ILLNESS HISTORY

Has your child suffered from any of the following? ***Circle any which apply:***

Allergic Conditions:
Eczema (dry, itchy rashes) Hay fever Asthma Hives Swelling Food allergies

Skin Problems:
Rashes/bumps Unusually colored patches of skin Too much sweating Too much dryness

Head:
Headaches Vision problems Crossed eyes Lazy eyes Wears glasses/contacts

Nose:
Nosebleeds Snoring Stuffy/runny nose Mouth breathing

Ears:
Middle ear infections Swimmer's ear infections Drainage from ear Hearing problems Tubes in the ears

Teeth:
Cavities Discoloration (color other than white on the teeth)

Throat:
Sore throats Tonsillitis Strep throat

Respiratory:
Pneumonia Bronchitis Cough Wheezing

Gastrointestinal:
Vomiting Belly pain Unusual weight gain Unusual weight loss

Stooling Patterns:
Constipation Diarrhea

Genito-Urinary:
Bed-wetting Stooling in panties Urinating too often Pain when urinating Blood in urine

Neuromuscular:
Coordination problems Problems sleeping Problems with energy level Convulsions or seizures

Has your child had any of the following: **Explain in detail where applicable:**

Allergies to Medications:

Any blood transfusions for any reason? No Yes: why?

Chicken Pox? Yes No Approximate date/age:

Hospitalizations:

Operations:

Serious injuries (broken bones, stitches, etc.):