PATIENT HISTORY

CHILD'S NAME_____ **DOB**_____

Form completed by:_____ **Relationship to child:**_____

Child's Birth History

Birth Weight_____ Was the baby born at term? _____ OR _____weeks Place of Birth_____

Was the delivery ☐ Vaginal ☐ Cesarean If Cesarean, why?_____

Any complications during pregnancy or delivery? ☐ Y ☐ N Explain: _____

How long did the baby stay in the hospital after birth?_____ Did baby pass the hearing test? ☐ Y ☐ N Did baby receive the Hepatitis B vaccine? ☐ Y ☐ N

Did baby have any problems? (i.e. Jaundice, respiratory distress, infection) _____

During pregnancy, did mother: Use tobacco ☐ Y ☐ N Drink Alcohol ☐ Y ☐ N Use drugs or medications ☐ Y ☐ N ☐ Used prenatal vitamins

What_____ When_____

Past Medical History

Has your child ever had any problems with the following? If YES, please explain:

☐ Y ☐ N ADHD _____
☐ Y ☐ N Asthma/RAD _____
☐ Y ☐ N Allergies (food/environmental) _____
☐ Y ☐ N Anemia/Blood Disorders _____
☐ Y ☐ N Bones/Joints _____
☐ Y ☐ N Chickenpox _____
☐ Y ☐ N Diabetes _____
☐ Y ☐ N Ears (multiple infections)/Hearing _____
☐ Y ☐ N Eyes/Vision _____

☐ Y ☐ N Gastro _____
(GE Reflux/Constipation/Diarrhea)
☐ Y ☐ N Heart _____
☐ Y ☐ N Repeated infections _____
☐ Y ☐ N Seizures/Headaches _____
☐ Y ☐ N Skin (Eczema) _____
☐ Y ☐ N Urine/Kidneys _____
Other_____

Hospitalizations _____

Surgeries _____

Current Social History

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

_____

☐ Y ☐ N If child is under 4'9", do you have them in a booster or car seat?
☐ Y ☐ N If child is less than 2 years old, are they in a rear facing car seat?
☐ Y ☐ N Do you and your child wear your seatbelt?
☐ Y ☐ N Do you have guns in the home?
☐ Y ☐ N If yes to above, do you keep them locked?
☐ Y ☐ N If your child is older than 6 months, do they use sunscreen?
☐ Y ☐ N Do you have pets in the home? _____
☐ Y ☐ N If you have a pool, do you have a gate surrounding it?
☐ Y ☐ N Are all of your medications and cleaners out of reach or locked?
☐ Y ☐ N Does your child wear a bicycle helmet when biking, skating or horseback riding?
☐ Y ☐ N Is anyone verbally or physically abusing you or your child?

Allergies to medications, food or insects:_____

_____

Family History

Relationship	Age, if Living	Age at Death & Cause of Death
Mother	_____	_____
Father	_____	_____

Siblings

How Many Sisters? _____ How Many Brothers? _____

Family Medical Problems

Please identify any medical problems blood relative have or ever have had.

Condition		Family Member(s) **Please indicate Maternal/Paternal**
Allergies	☐ Y ☐ N	_____
Anemia/Blood Disorders	☐ Y ☐ N	_____
Asthma	☐ Y ☐ N	_____
Birth Defects	☐ Y ☐ N	_____
Bone/Joint Disorders	☐ Y ☐ N	_____
Cancer	☐ Y ☐ N	_____
Diabetes	☐ Y ☐ N	_____
Eye or Ear Disorders	☐ Y ☐ N	_____

Condition		Family Member(s) **Please indicate Maternal/Paternal**
Genetic Defects	☐ Y ☐ N	_____
Heart Disease/Problems	☐ Y ☐ N	_____
Hepatitis B or C	☐ Y ☐ N	_____
High Blood Pressure	☐ Y ☐ N	_____
HIV/Aids	☐ Y ☐ N	_____
Kidney Disease/Problems	☐ Y ☐ N	_____
Lung Disease	☐ Y ☐ N	_____
Mental Disease/Disorder	☐ Y ☐ N	_____
Mental Retardation	☐ Y ☐ N	_____
Muscle Disorders	☐ Y ☐ N	_____
Rheumatoid Arthritis	☐ Y ☐ N	_____
Rheumatic Fever	☐ Y ☐ N	_____
Seizures/Convulsions	☐ Y ☐ N	_____
Skin Disease	☐ Y ☐ N	_____
Thyroid Disease	☐ Y ☐ N	_____
Tuberculosis	☐ Y ☐ N	_____

Other_____