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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  F  M  
 Your name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Where do you live: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 How long has the child been in your care? \_\_\_\_\_ Phone: \_\_\_\_\_  
 Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Years of Schooling completed: \_\_\_\_\_  
 Father's name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Years of Schooling completed: \_\_\_\_\_  
 Who lives in the home with this child? Number of adults: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
 Please list the names and ages of brothers and sisters:  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Pets: \_\_\_\_\_ Type: \_\_\_\_\_ Type of home:  Apartment  Trailer  House  
 Smokers in Household?  Yes  No Who? \_\_\_\_\_  
 Water Source:  City  Well  Bottled  County  
 What children's health reference books do you have in your personal library? \_\_\_\_\_

**MEDICAL HISTORY**

**Pregnancy History:** Did patient's mother use any of the following substances or have any of the following symptoms during pregnancy?

Y      N      Don't Know

**DOCTOR'S NOTES**

	Y	N	Don't Know		
Medications: Please name:					
Street drugs: Please name:					
Alcohol					
Smoking					
Vaginal infection					
Urine infection					
Other Problems:					

**Birth History:**

How long was the pregnancy:	
What hospital was the baby born at?	
What was the baby's birthweight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Did the baby have any problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	

**MEDICAL HISTORY**, continued....

	Y	N	Don't Know	DOCTOR'S NOTES
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have any allergies? To what?				
Does your child get regular dental care?				
Is your child on any medications? Please list:				
Has your child gone to an ER this past year?				
Has your child ever had:				
Ear infections?				
More than 2 strep throats?				
Pneumonia				
Heart problems				
Chickenpox				
Any major illness				
Reaction to any immunization or medications?				
Urinary tract infections?				
Wheezing?				

**Family History:** Check if close blood relatives have the following:

Disease	Y	N	Who?	Disease	Y	N	Who?
Asthma				Heart attack < 50 yrs			
Sickle cell disease				Urine infections			
Cystic fibrosis				Hayfever			
Tuberculosis				High blood pressure			
Kidney infections				Anemia blood problems			
Diabetes				Learning problems			
Hyperactivity				Seizures			
Mental retardation				Emotional problems			
Sudden death				Born w/heart problems			
Birth defects				Death shortly after birth			

**School / Daycare Behavior History**

Child's school \_\_\_\_\_ Grade: \_\_\_\_\_

	Y	N	Don't know	Doctor's Notes
Does child attend special classes or receive special help?				
Are you concerned about school behavior problems?				
Does your child have problems with:				
Frequent nightmares			N/A	
Difficult to control?			N/A	
Fighting a lot			N/A	
Trouble making friends?			N/A	
Bedwetting or stooling problems?			N/A	
Vision / Hearing			N/A	
Appetite			N/A	

Name of child's previous doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Are there any specific issues you would like to discuss with your doctor? \_\_\_\_\_

Signature of person completing form: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Reviewed by Dr.** \_\_\_\_\_ **Date:** \_\_\_\_\_