Practice Site

Patient Name: ______________________

DOB: _______________

Date: _______________

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

____

____

Current Problems:

____

____

History:

Birth History:

Birth Length: ________________
Discharge Weight: _____________
Duration of Labor: _____________

Birth Weight: ______________________
Gestational Age at Birth (weeks): ______

Birth Head Circumference: ___________
Delivery Method: □ Vaginal □ C-Section
If C-Section why? __________________

APGAR 1m: __________________
Infant Feeding: □ Breast □ Bottle □ Both

APGAR 5m: ________________________
Formula Name? ____________________

APGAR 10m: _______________________
Newborn Hearing Screening: □Pass □Fail

Other Comments: ____

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

Condition		
ADD/ADHD ____________________	YES	NO
Anemia ______________________	YES	NO
Congenital Heart Disease _________	YES	NO
Developmental Delay ____________	YES	NO
Eczema ______________________	YES	NO
GE Reflux ____________________	YES	NO
Murmur ______________________	YES	NO
Recurrent Otitis (ear infections) ___	YES	NO
Seizures _____________________	YES	NO
UTI _________________________	YES	NO
Vesicoureteral Reflux ___________	YES	NO

Condition		
Allergic Rhinitis ___________________	YES	NO
Asthma _________________________	YES	NO
Constipation _____________________	YES	NO
Diabetes ________________________	YES	NO
Food Allergies ____________________	YES	NO
Mental Illness ____________________	YES	NO
Prematurity ______________________	YES	NO
Recurrent Strep Throat _____________	YES	NO
Substance Abuse __________________	YES	NO
Vision Problems ___________________	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		
Gastronomy 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: ____

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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																		
Siblings	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: ☐ Parents ☐ Daycare ☐ Relatives ☐ Other: ____________________________

Daycare (hours/day): ___________

Time at relatives (hours/day): ___________

Pets: ☐ Yes ☐ No

Smokers in Home: ☐ Yes ☐ No If Yes, who? ____

Parent's Status:

Parent's marital status: ☐ Married ☐ Divorced ☐ Single ☐ Other: _____________________________

Mother's Occupation: ___________________________________ Father's Occupation: __________________________________