

Today's Date: \_\_\_\_\_

Child's previous Doctor's name: \_\_\_\_\_

Child's Name (first/last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age (yrs / months): \_\_\_\_\_

What is main reason for your visit? \_\_\_\_\_

**Allergies or Reactions to Medicines/Vaccines:**

_____	_____
_____	_____

**Current Medication(s) and Dosage(s):** (including vitamins/herbal/alternative treatments)

_____	_____
_____	_____

**Pregnancy & Birth:**

At what hospital was your child born? \_\_\_\_\_ City: \_\_\_\_\_

Is the child yours by: (circle one) Birth Adoption Stepchild

Were there any problems during pregnancy? (circle one) NO YES

If yes, please describe: \_\_\_\_\_

Delivery: (circle one) Vaginal C-Section If C-Section, why? \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

Premature delivery? (circle one) NO YES Mechanically ventilated? (circle one) NO YES

Were there any problems during the newborn period? (circle one) NO YES

If yes, please describe: \_\_\_\_\_

**Nutrition & Feeding:**

Was your child breastfed? NO \_\_\_ YES \_\_\_ If YES, how long? \_\_\_\_\_

Has your child had any feeding or dietary problems? NO \_\_\_ YES \_\_\_ If YES, please specify: \_\_\_\_\_

Vegetarian or Non-vegetarian diet? \_\_\_\_\_

**Sleep:**

How many hours per night? \_\_\_\_\_ Naps? (number and length) \_\_\_\_\_

Does your child have any sleep problems? NO YES If YES, please specify: \_\_\_\_\_

**Development:**

At what age did your child: (fill in each below)

Sit alone: \_\_\_\_\_ Walk alone: \_\_\_\_\_ Say words clearly: \_\_\_\_\_ Toilet train: \_\_\_\_\_

Dress alone: \_\_\_\_\_ Read: \_\_\_\_\_

Girls only: Age of first menstrual period: \_\_\_\_\_

**Dental History:**

Has your child been seen by a dentist? NO YES Date of last dental visit: \_\_\_\_\_

**Medical History:** NONE (Please list any major medical problems and their dates of onset, if any)

Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____

**Hospitalizations / Surgeries / Major Injuries / Broken Bones?** NONE (or Please list with dates)

Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____

**Immunizations:** Please bring all immunization records to child's appointment.

Has your child had any of the following diseases: *Chickenpox?*  NO  YES *Measles?*  NO  YES  
*Mumps?*  NO  YES *Rubella?*  NO  YES *Meningitis?*  NO  YES *TB?*  NO  YES

**Family Health Information:**  
 Please write the relationship of the person with the condition, if applicable, otherwise check NO:

Asthma: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Stroke: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
Diabetes: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Cancer: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
Seizures: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Anemia: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
Genetic Disorder: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Liver disease: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
Mental Health Disorder: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Thyroid disease: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
High Blood Pressure: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Kidney disease: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____
Sickle Cell trait/disease: NO <input type="checkbox"/> YES <input type="checkbox"/> Relation: _____	Other Family Health Information: None <input type="checkbox"/> _____ Type: _____ Relation: _____

**Social History:**

Who else, besides yourself, lives in your home with the child? No One \_\_\_\_\_

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are the child's primary caregivers: Married  Unmarried  Divorced/Separated  Other?

**Exposures:**

Do any household members smoke? NO  YES

Any concerns about lead exposure? (old home? peeling paint?) NO  YES

Are there guns in the home? NO  YES  If YES, are they locked? YES  NO

Are there pets in the home? NO  YES  If YES, what kinds? \_\_\_\_\_

TV hours watched by child per day? \_\_\_\_\_ Computer/Video Games hours played by child per day? \_\_\_\_\_

**School History:**

What grade is your child in? \_\_\_\_\_ At which school? \_\_\_\_\_ Where? \_\_\_\_\_

Is your child involved in any sports/exercise? NO  YES  If yes, please describe: \_\_\_\_\_

Do you have any concerns about your child's school performance? NO  YES

If YES, please describe: \_\_\_\_\_

Do you have any concerns about your child's relationship with other students or teachers? NO  YES

If YES, please describe: \_\_\_\_\_

Is there any important information about your child that we missed? \_\_\_\_\_

**Optional:** How did you hear about our practice? Friend  Family  Newspaper  Ad/ Mailer

Name of person completing form (please print): \_\_\_\_\_  
 Relationship to Child (please print) \_\_\_\_\_ Your Age: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: (Provider name) \_\_\_\_\_ Date: \_\_\_\_\_