



PATIENT HISTORY

Patient's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to child: _____

PREGNANCY & BIRTH HISTORY

Where was your child born? _____

Problems during pregnancy: _____

Mother's medication during pregnancy: _____

Type of Delivery: vaginal C-section, reason: _____

Number of weeks Gestation: _____ Birth Weight: _____

Problems during delivery or newborn period: _____

PAST HISTORY:

Has your child ever been diagnosed with or treated for any of the conditions below?

<input type="checkbox"/> Asthma/Reactive Airways <input type="checkbox"/> Wheezing or Bronchiolitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Recurrent Ear Infections <input type="checkbox"/> Recurrent Strep Throat <input type="checkbox"/> Recurrent Sinus infections <input type="checkbox"/> Food allergies <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Eczema <input type="checkbox"/> Other Skin Conditions <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Growth Hormone Deficiency	<input type="checkbox"/> Anemia <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Bleeding/Clotting disorder <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Other Heart Conditions <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> Constipation <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Failure to Thrive <input type="checkbox"/> Gastroesophageal Reflux (GERD)	<input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Broken Bones <input type="checkbox"/> Vision/Hearing Problem <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Speech Delay or Disorder <input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Other Learning Disorder <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Alcohol/Drug/Tobacco Use <input type="checkbox"/> Other Medical Conditions
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Please explain any other conditions _____

List any specialist your child sees and the reason: _____

Has your child ever had surgery? Explain: _____

Has your child ever been hospitalized? Explain: _____

MEDICATIONS:

Is your child allergic to any medications or vaccines? No Yes, please list: _____

Prescription medications your child takes: _____

Over-the-counter medications: _____ Vitamins/Supplements: _____



SOCIAL HISTORY

Is the child yours by Birth Adoption Step-child Other

Who does your child live with? Mom Dad Step-Parent Grandparents Siblings Other _____

Number of siblings _____

Child's parents are: married/together separated, shared custody separated, sole custody other

Does anyone in the household smoke? No Yes

Are there any guns in the home? No Yes

FAMILY HISTORY:

Has anyone in your child's family ever had any of the following conditions?

	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Explain</u>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Born with heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol or drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please explain any other conditions:

Physician signature: _____ Date: _____