

Patient's Name: _____

Birth date: _____ Current age: _____ Gender: M F

Previous doctor: _____ City & State: _____

Reason for changing doctors: _____

Person who is filling out this form: _____ Relation to patient: _____

SOCIAL HISTORY

Who lives in the home with this child?

Full Name	Age	Relation to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any pets at home (inside or outside)? No Yes: _____

Does anyone smoke (inside or outside)? No Yes (who): _____

We recommend that your baby/child is NOT around any tobacco smoke. Exposure to tobacco smoke or even the smell of smoke can increase your baby's child's risk for "colds," ear infections, bronchitis, and asthma. It also can increase your baby's risk of Sudden Infant Death Syndrome.

Does / will your baby/child go to daycare? No Yes If yes, where & hr/week: _____

Does your child go to preschool? No Yes If yes, where & hr/week: _____

What are the parents' occupations?

Mother/partner: _____ Father/Partner: _____

What is the parent's education? Please indicate the highest level of education:

Mother/partner: _____ Father/Partner: _____

If this child or the parents or was/were NOT born in the US, which country are you from? _____

GROWTH

If available, please note your child's length, height, and weight at the following ages:

	2 mos	4 mos	6 mos	9 mos	1 year	18 mos	2 years	3 years	4 years	5 years
Height										
Weight										
Head Circ.										

LAB WORK OR DIAGNOSTIC TESTING

If your child has had any special lab work or diagnostic tests done, please note them (for example, blood tests, x-rays, CT scan, ultrasound, endoscopy, EEG, EKG, etc.)

Date	Place Tests Were Done	Test	Reason	Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SPECIALISTS OR CLINICS

Does your child see any other specialists or clinics: (Not only physicians, but please include psychologists, counselors, physical, occupational, or speech therapists, Meningomyelocele Clinic, Developmental Assessment Clinic, etc.)

Name	Address	Reason Seen	Date Last Seen

FAMILY MEDICAL HISTORY:

Please note if present in family members (parents, siblings, grandparents, others related by blood):

- | | |
|---|--|
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Colitis (Crohn's or ulcerative colitis): _____ |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Irritable bowel syndrome: _____ |
| <input type="checkbox"/> Diabetes mellitus: _____ | <input type="checkbox"/> Kidney stones: _____ |
| <input type="checkbox"/> Thyroid problems: _____ | <input type="checkbox"/> Bladder or kidney problems: _____ |
| <input type="checkbox"/> Sickle cell anemia: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Other anemia: _____ | |
| <input type="checkbox"/> Seizures: _____ | <input type="checkbox"/> Heart attack or problems (before 50 years old): _____ |
| <input type="checkbox"/> Migraines: _____ | |
| <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> Other heart problems: _____ |
| <input type="checkbox"/> Anxiety: _____ | <input type="checkbox"/> High cholesterol: _____ |
| <input type="checkbox"/> Attention deficit/hyperactivity: _____ | <input type="checkbox"/> Death of child or young adult: _____ |
| <input type="checkbox"/> Alcohol / drug abuse: _____ | <input type="checkbox"/> Other medical problems: _____ |
| <input type="checkbox"/> Bleeding disorder: _____ | |

PREVIOUS MEDICAL PROBLEMS

Pregnancy: during pregnancy with THIS child, did the mother...

Have any illness or medical condition during pregnancy? No Yes: _____

Need to take any medication during pregnancy? No Yes: _____

- Use any tobacco? No Yes: _____
 Drink alcohol? No Yes: _____
 Use any drug? No Yes: _____

Labor and delivery:

Was the baby born on the due-date? Yes No How early or late? _____

Type of delivery: vaginal forceps vacuum C-section (reason) _____

Any problems during labor or delivery? No Yes: _____

Baby's birth weight: _____ birth length: _____ Apgar scores: _____ (1 min) _____ (5 min)

Did this baby have any problems during the hospital stay? Yes No Jaundice

Breathing: _____ Feeding: _____

Other: _____

Did mother and baby go home from the hospital together? Yes No Why not? _____

Number of days in the hospital: _____ mother _____ baby

Hospital/Facility of Birth: _____ City/State: _____

Infant feeding:

Did you breastfeed your baby? No Yes For how long? _____

If you are still breastfeeding, how long do you plan to breastfeed? _____

If you formula-fed your baby, what kind of formula is / was your baby on? _____

Patient Name: _____ DOB _____

Has patient had any of these problems since birth?

- | | |
|--|--|
| <input type="checkbox"/> Problems seeing or hearing: _____ | <input type="checkbox"/> Lead poisoning: _____ |
| <input type="checkbox"/> Ear infections: _____ | <input type="checkbox"/> Any glandular problems (diabetes, thyroid, etc.): _____ |
| <input type="checkbox"/> Strep throat: _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Nasal allergies: _____ | <input type="checkbox"/> Migraines: _____ |
| <input type="checkbox"/> Wheezing: _____ | <input type="checkbox"/> Seizures: _____ |
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Head injury: _____ |
| <input type="checkbox"/> Intubated: _____ | <input type="checkbox"/> Other neurological problems: _____ |
| <input type="checkbox"/> Croup: _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pneumonia: _____ | <input type="checkbox"/> Bladder/kidney infection: _____ |
| <input type="checkbox"/> Tuberculosis: _____ | <input type="checkbox"/> Other bladder/kidney problem: _____ |
| <input type="checkbox"/> Other breathing or respiratory problem: _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Any stomach or digestive problems: _____ |
| <input type="checkbox"/> Heart murmur: _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Other problems with the heart: _____ | <input type="checkbox"/> Any broken bones: _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Any stitches: _____ |
| <input type="checkbox"/> Anemia: _____ | <input type="checkbox"/> Any poisoning: _____ |
| <input type="checkbox"/> Sickle Cell Anemia: _____ | <input type="checkbox"/> Any burns that needed a doctor's care: _____ |
| <input type="checkbox"/> Bleeding disorder: _____ | <input type="checkbox"/> Attention deficit / hyperactivity: _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Any other conditions: _____ |
| <input type="checkbox"/> Blood transfusion: _____ | <input type="checkbox"/> _____ |

Has your child ever received counseling for a behavioral problem or concern? No Yes: _____

Has your baby/child ever been in the Emergency Room? No Yes: (date and reason) _____

Has your baby/child ever had any surgery? No Yes:

Date	Surgery	Reason	Hospital (Name & City)	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your baby/child ever stayed overnight in the hospital (except at birth)? No Yes

Date	Hospital (Name & City)	Reason	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

Has your baby/child ever had an allergic reaction to food? No Yes

Food	Reaction	Is an Epi-pen (Jr.) required ?	If so, when does Epi-pen (Jr.) expire
_____	_____	_____	_____
_____	_____	_____	_____

List all medications; including medications taken daily and those taken as needed (prescribed and over-the-counter) None

Medication	Dosage	Reason for medication	When started
_____	_____	_____	_____
_____	_____	_____	_____

Has your baby/child ever had an allergic reaction to medications? No Yes

Medication	Reaction
_____	_____
_____	_____

Does your baby/child have any of these symptoms now? None

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> fever | <input type="checkbox"/> wheeze | <input type="checkbox"/> constipation | <input type="checkbox"/> pain with urination |
| <input type="checkbox"/> headache | <input type="checkbox"/> feeling short of breath | <input type="checkbox"/> rash | <input type="checkbox"/> limping |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> chest pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> joint or muscle pain |
| <input type="checkbox"/> stuffy nose | <input type="checkbox"/> stomach ache | <input type="checkbox"/> looks pale | <input type="checkbox"/> joint swelling |
| <input type="checkbox"/> ear pain | <input type="checkbox"/> nausea | <input type="checkbox"/> irritability | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> vomiting | <input type="checkbox"/> behavior changes | |
| <input type="checkbox"/> cough | <input type="checkbox"/> diarrhea | <input type="checkbox"/> urinating more often | |

Tuberculosis screen: Yes to any of these questions No to all of these questions

Has your child:

- had any contact with any one who has confirmed or suspected infectious tuberculosis?
- had any contact with anyone who has been at any County Youth Center, or detained in a law-enforcement facility (such as a jail or prison) within the last 5 years?
- visited any countries for more than 3 weeks?
Asia, Middle East, Africa, Latin or South America, Eastern Europe
- had daily contact for more than 3 weeks with any of the following individuals: HIV infected; homeless; residents of nursing homes or institutions; users of illicit drugs; migrant farm workers; foster children with exposure to adults in the above high-risk groups?
- had daily contact for more than 3 weeks with people who have traveled to or lived in countries in these areas?
Asia, Middle East, Africa, Latin or South America, Eastern Europe

Does your child have parents who have lived in any countries from these areas? *Asia, Middle East, Africa, Latin America, Eastern Europe*

Cholesterol screen: Answer only if your child is 5 years old or older.

Have the child's parents or grandparents had any of these problems *when they were younger than 55 years old*?

- heart attack angina stroke hardening of the arteries sudden death from a heart problem
 heart surgery (by-pass or balloon angioplasty) cholesterol level more than 240

DEVELOPMENT

For children LESS THAN 5 YEARS OLD, please note the age at which your baby/child achieved this milestone:

_____ Sat up well without support _____ Walked _____ Spoke in 3-5 word sentences
_____ Crawled _____ Talked (first couple of words) _____ Dressed self

For children AT LEAST 5 YEARS OLD, please describe their school progress:

Current grade level _____ Current school: _____

Ever repeated a grade? No Yes: _____ Ever advanced a grade? No Yes: _____

Has your child had any difficulties in school (either socially or academically): No Yes: _____

What kind of grades or evaluation does your child usually get? Excellent Good OK So-so Poor

Any recent changes in grades either upwards or downwards? No Yes: _____

How does your child feel about their grades? Very pleased Satisfied Unsatisfied

How do you feel about your child's grades? Very pleased Satisfied Unsatisfied

Do you have any concerns about your child's school progress? No Yes: _____

SOCIAL LIFE

Is your child adopted? No Yes: If adopted, at what age did he/she come to live with you? _____
at what age was he/she adopted? _____ Does your child know he/she is adopted? No Yes

What kind of hobbies, extra-curricular activities, or sports does your child participate in? _____

What does your child want to be when she/he grows up? _____

Does your child operate or ride on lawn or farm equipment? No Yes: _____

Does your child ride an RV (recreational vehicle)? No Yes: _____

Is there anything else you would like us to know about your child? _____

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____