

Patient History

Name: _____

Acc. Number: _____

Birth date: _____ Age _____

Form completed by: _____ Date completed: _____

HOUSEHOLD:

Please list all those living in the child's home:

Name	Relationship to child	Birth date	Health problems

Are there any siblings not listed? If so, please list their names and ages and where they live: _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/s not in the home? _____

BIRTH HISTORY:

Birth weight: _____ Method of delivery: _____ vaginal _____ cesarean

If by cesarean section, why: _____

Was the baby born term: _____ early: _____ if early, how many weeks: _____

Did your baby have any problems right after birth? _____ Yes _____ No

If yes, explain problems: _____

Did mother have any illness or problems with her pregnancy: _____ Yes _____ No

If yes, explain: _____

How was baby fed initially breast _____ bottle _____

During pregnancy, did mother smoke: _____ Yes _____ No

Drink alcohol _____ Yes _____ No / Use drugs or medications: _____ Yes _____ No

If yes, what medications or drugs were used: _____

Was the baby discharged home with the mother: _____ Yes _____ No

If no, explain _____

GENERAL:

Do you consider your child to be in good health: _____ Yes _____ No Explain _____

Does your child have any serious illness or medical conditions: _____ Yes _____ No Explain _____

Has your child had serious injuries or accidents: _____ Yes _____ No Explain _____

Has your child had any surgery: _____ Yes _____ No Explain _____

Has your child ever been hospitalized: _____ Yes _____ No Explain _____

Is your child allergic to any medicines or drugs: _____ Yes _____ No Explain _____

DEVELOPMENT:

Are you concerned about your child's physical development? _____ Yes _____ No Explain _____

Are you concerned about your child's mental or emotional development? _____ Yes _____ No Explain _____

Are you concerned about your child's attention span? _____ Yes _____ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

FAMILY HISTORY:

Have any members of the family had the following:

- Deafness Yes ___ No ___ Who _____
 - Nasal allergies Yes ___ No ___ Who _____
 - Asthma Yes ___ No ___ Who _____
 - Tuberculosis Yes ___ No ___ Who _____
 - Heart disease (before 50 years old) Yes ___ No ___ Who _____
 - High blood pressure (before 50 y.o.) Yes ___ No ___ Who _____
 - High cholesterol Yes ___ No ___ Who _____
 - Anemia Yes ___ No ___ Who _____
 - Bleeding disorder Yes ___ No ___ Who _____
 - Liver disease Yes ___ No ___ Who _____
 - Kidney disease Yes ___ No ___ Who _____
 - Diabetes (before 50 y.o.) Yes ___ No ___ Who _____
 - Bed-wetting (after 10 y.o.) Yes ___ No ___ Who _____
 - Epilepsy or convulsions Yes ___ No ___ Who _____
 - Alcohol abuse Yes ___ No ___ Who _____
 - Drug abuse Yes ___ No ___ Who _____
 - Mental illness Yes ___ No ___ Who _____
 - Mental retardation Yes ___ No ___ Who _____
 - Immune problems, HIV or AIDS Yes ___ No ___ Who _____
- Additional family history or comments: _____
- _____
- _____

PAST HISTORY:

Does your child have, or has he/she ever had:

- Chickenpox: Yes ___ No ___ When _____
 - Frequent ear infections Yes ___ No ___ Explain _____
 - Problems with ears or hearing Yes ___ No ___ Explain _____
 - Nasal allergies Yes ___ No ___ Explain _____
 - Problems with eyes or vision Yes ___ No ___ Explain _____
 - Asthma, bronchitis, bronchiolitis, pneumonia Yes ___ No ___ Explain _____
 - Any heart problem or heart murmur Yes ___ No ___ Explain _____
 - Anemia or bleeding problems Yes ___ No ___ Explain _____
 - Blood transfusions Yes ___ No ___ Explain _____
 - Frequent abdominal pain Yes ___ No ___ Explain _____
 - Constipation requiring doctor visits Yes ___ No ___ Explain _____
 - Bladder or kidney infections Yes ___ No ___ Explain _____
 - Bed-wetting (after 5 y.o.) Yes ___ No ___ Explain _____
 - (for girls) has she started menstrual period? Yes ___ No ___ When _____
 - (for girls) are there problems with period? Yes ___ No ___ Explain _____
 - Any chronic or recurrent skin problems? Yes ___ No ___ Explain _____
 - (acne, eczema, etc)
 - Frequent headaches Yes ___ No ___ Explain _____
 - Convulsions or other neurologic problems Yes ___ No ___ Explain _____
 - Diabetes Yes ___ No ___ Explain _____
 - Thyroid or other endocrine problems Yes ___ No ___ Explain _____
 - Any other significant problem Yes ___ No ___ Explain _____
 - Use of alcohol or drugs Yes ___ No ___ Explain _____
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