Date:________________________

Patients Name: ________________________________ **Date of Birth**: _________________

Parents/Guardians Name(s): ____

Allergies: (Medications, Environmental, Foods)
____
____
____

Current Medications: (Prescribed, Over the Counter, and Herbal)
____
____
____

Birth History: (ONLY FILL OUT IF UNDER 5 YEARS OLD)

Birth Weight _____________________ # weeks at delivery ______ Vaginal Delivery/C-Section

Any birth or delivery complications:__________________________

Past Medical History:	yes	or	no	**Details:**
Asthma	x		x	____________________
Bronchiolitis	x		x	_____________________
Upper Respiratory Infections	x		x	_____________________
Asthma	x		x	_____________________
Reactive Airway Disease	x		x	_____________________
Bronchitis	x		x	_____________________
Ear Infections	x		x	_____________________
Pneumonia	x		x	_____________________
Sinus Infections	x		x	_____________________
Staph/MRSA	x		x	_____________________
Urinary Tract Infections	x		x	_____________________
Mental Health Problems	x		x	_____________________
ADD/ADHD	x		x	_____________________
Developmental Delay	x		x	_____________________
Obesity	x		x	_____________________
Seizures	x		x	_____________________
Eczema	x		x	_____________________
Broken Bones	x		x	_____________________
GERD	x		x	_____________________
Missed Immunizations	x		x	_____________________
Birth Defect	x		x	_____________________
Jaundice	x		x	_____________________
Hearing Problems	x		x	_____________________
Vision Problems	x		x	_____________________
Heart Murmur	x		x	_____________________
Past Concussion	x		x	_____________________
Loss of Consciousness	x		x	_____________________
Overnight in Hospital	x		x	_____________________

Other: ____
____

Surgical History:	yes	or	no	Details:
Tonsillectomy/Adenoidectomy	x		x	_____________________
Ear Tubes	x		x	_____________________
Appendectomy	x		x	_____________________
Bone Surgery	x		x	_____________________

Other: ____
____

PGM= Paternal Grandmother PGF=Paternal Grandfather
MGM= Maternal Grandmother MGF= Maternal Grandfather

Family History:	mom	dad	brother sister	PGF	PGM	MGF	MGM	Details:
Asthma	x	x	B/S	x	x	x	x	
Heart Disease	x	x	B/S	x	x	x	x	
Heart Attack	x	x	B/S	x	x	x	x	
Stroke	x	x	B/S	x	x	x	x	
Cancer	x	x	B/S	x	x	x	x	
Thyroid Problems	x	x	B/S	x	x	x	x	
Kidney Problems	x	x	B/S	x	x	x	x	
Diabetes	x	x	B/S	x	x	x	x	
Obesity	x	x	B/S	x	x	x	x	
Genetic Abnormalities	x	x	B/S	x	x	x	x	
Drug or Alcohol Abuse	x	x	B/S	x	x	x	x	
Mental Health Problems	x	x	B/S	x	x	x	x	
Seizures	x	x	B/S	x	x	x	x	
Anemia	x	x	B/S	x	x	x	x	
Bleeding Disorders	x	x	B/S	x	x	x	x	
Tuberculosis	x	x	B/S	x	x	x	x	
Hepatitis	x	x	B/S	x	x	x	x	
Problems w/ Hearing	x	x	B/S	x	x	x	x	
Problems w/ Vision	x	x	B/S	x	x	x	x	
Nasal Allergies	x	x	B/S	x	x	x	x	
Immune Disorders	x	x	B/S	x	x	x	x	

Other: ____
____
____

Social History:	yes	or	no	**Details:**
Adopted	x		x	
Parents Divorced	x		x	
Currently in Daycare	x		x	

Grade your child is in________________________ Any Problems__________________________

Who lives in your home and relationship

Person	Relationship
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________
__________________________	_________________________

Are there any other concerns about your child's health: ___________________________________
____