



Name: _____
 Today's Date: _____
 Date of Birth: _____

Dear Patients: Please complete as much of this form as you can.
 It will help us learn more about your child and help us to give him/her a better examination.

Current Information

What is the reason for today's visit? _____

 Is your child now taking any medications? _____
 List any medications to which your child may be allergic and describe the reaction: _____

 Does your child have any severe reaction to foods or insect bites? _____

Past History

List any major problems with pregnancy, delivery, newborn period: _____

 Are your child's immunizations up to date? Yes No (Please provide us with a copy.)
 Cities in which child has lived: _____
 Do parents or caretakers smoke? Yes No Age at first menstrual period: _____
 Are there pets in the home/yard? _____
 Does patient eat dirt, paint or other nonfood items? _____
 Please list any hospitalizations, operations, injuries, or serious illnesses and the year or age they occurred.

Family History

	<u>Name</u>	<u>Age/Height/Weight</u>	<u>Condition of Health</u>	<u>Occupation</u>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Please list relationships of immediate or extended family members who have the following problems:

Allergies: _____
 Asthma: _____
 Blood disorders, including Sickle Cell: _____
 Birth defects: _____
 Bleeding problems: _____
 Convulsions or epilepsy: _____
 Cystic Fibrosis: _____
 Diabetes (adult or childhood): _____
 Heart disease in children: _____
 Heart disease in adults under 55 years:
 Heart attacks: _____ Hardening of the arteries: _____
 Strokes: _____ Heart bypass: _____
 Angina: _____
 High cholesterol (over 240 or on medication): _____
 High blood pressure: _____
 Mental retardation: _____
 Migraine headaches: _____
 Thyroid disease: _____
 Tuberculosis: _____
 Other: _____

Does your child have a history of the following problems? (Now or in the past)

- Allergy, hay fever, or sinus problems
- Asthma, wheezing, or shortness of breath
- Bronchitis or pneumonia
- Chronic cough
- Frequent throat infections, tonsillitis, or colds
- Hearing problems
- Heart murmur or other problems
- Frequent chest pain
- Convulsions or staring spells
- Dizziness or fainting
- Frequent headaches
- Head injury or concussion
- Unusual clumsiness
- Vision problems
- Excessive sweating
- Excessive thirst
- Growth problems or weight loss
- Abdominal pain, chronic
- Bloody or tarry stools
- Constipation or diarrhea
- Soiling pants
- Vomiting or nausea, chronic
- Anemia
- Easy bleeding or bruising
- Sickle cell trait or disease
- Chickenpox
- Mononucleosis
- Measles
- Exposure to tuberculosis
- Frequent unexplained fever
- Deformities
- Joint swelling or pain
- Urinary tract or bladder infections
- Frequent or painful urination
- Bedwetting or daytime wetting
- Menstrual irregularity or abnormality
- Eczema or other skin problems
- Grade in school _____ Usual grades _____
- Behavior problems
- School problems
- Easily saddened or depressed
- Mood swings
- Change in appetite or sleep habits