



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male  Female

**BIRTH HISTORY**

**Pregnancy:**

Did mother:  
 smoke?  Yes  No    drink alcohol?  Yes  No  
 use drugs/medications?  Yes  No  
 If yes, what kind(s)? \_\_\_\_\_  
 Experience illness/complications?  Yes  No  
 If yes, what kind(s)? \_\_\_\_\_

**Delivery/Newborn Period:**

Delivery Type:  vaginal  c-section  
 Gestational Age: \_\_\_\_\_  
 Birth Weight: \_\_\_\_\_ Date Hepatitis B given: \_\_\_\_\_  
 Problems in Newborn Period: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY**

Has your child had any of the following?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Bronchiolitis            | <input type="checkbox"/> Fracture            | <input type="checkbox"/> Prematurity              |
| <input type="checkbox"/> Abdominal Pain    | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> GE Reflux/Heartburn | <input type="checkbox"/> Kidney Infection         |
| <input type="checkbox"/> Acne              | <input type="checkbox"/> Chickenpox               | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Recurrent Ear Infections |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Concussion               | <input type="checkbox"/> Hearing Problems    | <input type="checkbox"/> Seizure Disorder         |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Seizures Febrile         |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Menstrual Problems  | <input type="checkbox"/> Sleep Problems           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Urinary Reflux           |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Urinary Tract Infection  |

**PAST SURGICAL HISTORY**

Date	Surgery	Surgeon

**FAMILY MEMBERS**

Name	Relationship	Date of Birth	Living in home?	Smoker?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Who cares for the child?**

# days/week  
 Mother \_\_\_\_\_  
 Father \_\_\_\_\_  
 Other family \_\_\_\_\_  
 Daycare \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Have any family members had the following conditions?

Condition	M	F	S	M	P	U	Condition	M	F	S	M	P	U	Condition	M	F	S	M	P	U
				G	G	A					G	G	A					G	G	A
ADD/ADHD							Developmental Delay							Migraines						
Allergies							Diabetes							Obesity						
Asthma							Eczema							Curved Spine						
Birth Defects							Genetic Disorder							Seizure Disorder						
Cancer							Blood Disorder							Sudden Infant Death						
Heart Problems							High Cholesterol							Crossed Eyes						
Hip Problems							High Blood Pressure							Thyroid Disease						
Deafness							Learning Disability							Other:						
Depression							Mental Retardation													

M = Mother    F = Father    S = Sibling    MG = Mat. Grandparent    PG = Pat. Grandparent    UA = Uncle/Aunt