Initial History

Name of Patient:_____
Sex:___ Male ___ Female DOB___/___/___

Form Completed by:_____
Relationship to patient_____

Current Medical History

Are your child's immunizations up to date: ___yes ___no
Is your child having any ongoing medical problems: __yes__no
Is your child being followed by any other physicians/ specialists?

_____

_____

Current Medications:
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Any drug allergies?_____

List family members living in the home:			
Name	Relation	Age	Health Problems

Development

Has your child had a history of.....	yes	no	*Reason*
Delayed physical development?			
Mental or emotional problems?			
Learning disability?			
Prob. with attention span or activity level?			

If in school, has the patient had.....	yes	no	*Reason*
Tutoring outside of the classroom?			
To repeat a grade?			
Educational or psychological testing?			
Behavioral problems?			

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:	**Yes**	**No**	**Explain**
A serious medical problem?			
Been hospitalized or had surgery?			
Had a serious injury or accident?			
Chickenpox? When?_____			
Allergies, asthma, bronchitis, respiratory infections?			
Repeated ear infections, tubes, difficulty with hearing?			

Problems with eyes or vision?			
Heart problems or heart murmur?			
Anemia, bleeding problems or blood transfusion?			
Abdominal pain, constipation requiring doctor visits?			
Recurrent vomiting, recurrent diarrhea, blood in stools?			
Bladder or kidney infections, bed-wetting after 5 years?			
Recurrent skin problems (acne, eczema, etc)?			
Headaches, convulsions, other endocrine problems?			
Diabetes, thyroid or other endocrine problems?			
If female, has she started her menstrual periods?			LMP__/__/__Any problems?

Maternal and Newborn History

Pregnancy *Check if mom had any of the following:*

___excessive wt. gain ___urinary infections ___excessive swelling ___toxemia ___venereal disease

Did mother smoke, use drugs or alcohol during pregnancy? ___ yes ___no

Birth

Birth Weight_____ Length_____ Apgar_____ Was baby born at:___ Term ___ Early___ Late

If early, how many weeks gestation?_____ ___C-section delivery ___Vaginal delivery

Was labor difficult or prolonged? ___yes ___no

Newborn *Check if the pt had any of the following problems:*

__feeding problems __Breast feeding __Formula __slow weight gain __multiple formula changes

__colic __jaundice __recurring vomiting __ recurring diarrhea

__blood in stool __other_____