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:_____

Place of Birth: _____

Past Medical History:	yes	or	no	**Date & Details:**
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/Reflux	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	**Date & 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	**Date & 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	**Date & 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: _____

_____