Patient History

Name_____ **Birth date**_____

Family History

	Date of Birth	Ht	Wt	Medical Problems	Education Level
MOTHER					
FATHER					

Is there a family history of any of the following (include child's parents, siblings, grandparents, aunts and uncles)?
Please check yes or no to all questions.

Diabetes	Yes ❑	No ❑	Allergies	Yes ❑	No ❑	Birth Defects	Yes ❑	No ❑
Asthma/Wheezing	Yes ❑	No ❑	Cancer	Yes ❑	No ❑	Tuberculosis	Yes ❑	No ❑
Bleeding Disorder	Yes ❑	No ❑	High Cholesterol	Yes ❑	No ❑	Epilepsy	Yes ❑	No ❑
Thyroid disease	Yes ❑	No ❑	High Blood Pressure	Yes ❑	No ❑	Kidney Disease	Yes ❑	No ❑
Mental Problems	Yes ❑	No ❑	Early Heart Attacks	Yes ❑	No ❑	Cystic Fibrosis	Yes ❑	No ❑
Convulsions	Yes ❑	No ❑	Other Heart Disease	Yes ❑	No ❑	Other Illnesses	Yes ❑	No ❑

If you answered yes to any of the above, please explain _____

Prenatal History

Did you take hormones during pregnancy? Yes ❑ No ❑
Did you take any drugs during pregnancy? Yes ❑ No ❑
Did you smoke during pregnancy? Yes ❑ No ❑
Did you drink any alcoholic beverages during pregnancy? Yes ❑ No ❑
Other:_____

Birth History

Circle one: Full term pregnancy Premature birth at_____ weeks Adopted - At what age?_____
Has he/she been told he's adopted? Yes ❑ No ❑ Where was child born?_____
Type of delivery_____ Obstetrician_____
Birth weight_____ Length_____ Head circumference._____ Apgars_____
Circle one: Breast fed Bottle fed How many ounces does he/she drink in a 24-hour period? _____
Any problems at birth? Please specify_____

Past Illnesses

Please mark date or frequency of illness or specify substance causing allergy

Roseola	_____	Asthma	_____	Rubella (German measles)	_____
Chicken Pox	_____	Heart Murmur	_____	Allergic to Medication	_____
Mumps	_____	Colds	_____	Allergic to Foods	_____
Tonsillitis	_____	Scarlet fever	_____	Allergic to Insect Bites	_____
Pneumonia	_____	Ear infections	_____	Other_____	
Convulsions	_____	Urinary infections	_____	Has child received desensitization shots? _____	

Surgeries Hospitalizations

Please specify date or reason

Operations: _____
Hospitalizations: _____
Other:_____

Other

Is you child taking any medication on a regular basis? Yes ❑ No ❑
Please specify _____

Is there anything else about your child you feel we need to know to provide the best medical care for him/her?
Please specify _____

You have completed the questionnaire. Please return to the front office so your doctor can review this information before your child's examination. Thank you!