

Please fill out this form. It will speed up your visit and allow me to serve you better.
All answers are, of course, confidential. Today's Date _____

Child's Name _____ Home Phone # _____

Child's Address _____

Birthdate _____ Age _____

Parent _____

Occupation _____ Work Phone # _____

Parent _____

Occupation _____ Work Phone # _____

Child lives with (List all people in household) _____

Circle your marital status: Married Separated Single Remarried Divorced Widowed

Brothers or sisters?

Name _____ DOB _____ Sex _____

Name _____ DOB _____ Sex _____

Name _____ DOB _____ Sex _____

Name _____ DOB _____ Sex _____

(Please include siblings related through only one parent and specify which parent?)

Child's school (if applicable) _____

Pregnancy History (to be filled out by mother). Circle the correct response.

Were you on any medicine or drugs during the pregnancy? Yes No Don't Know

If so, what? _____

Did you smoke cigarettes during the pregnancy? Yes No Don't Know

If so, how much? _____

Did you drink alcohol during the pregnancy? Yes No Don't Know

If so, how much? _____

Was the delivery a breech (bottom first)? Yes No Don't Know

Did you have any type of infection during the pregnancy? Yes No Don't Know

Type _____

How long was the pregnancy? ____ months What was the birth weight? _____

Did you have a C-Section? Yes No Don't Know

Did the baby go home with you from the hospital? Yes No Don't Know

Did the baby have any problems? Yes No Don't Know

Did you breast feed? Yes No Don't Know

If so, how long? _____

Has your child ever been hospitalized overnight? Yes No Don't Know

Has your child ever had surgery other than stitches for cuts? Yes No Don't Know
For what? _____

Is your child allergic to any drugs? Yes No Don't Know

Specify drug and what happened _____

Is your child allergic to anything else? Yes No Don't Know

What? _____

Has your child ever had

Behavioral or family counseling Yes No Don't Know

Specify type of problem _____

Special school evaluation or assistance Yes No Don't Know

Pneumonia Yes No Don't Know

Heart problems Yes No Don't Know

Chickenpox Yes No Don't Know

Any major illness Yes No Don't Know

A reaction to any immunization or medicines Yes No Don't Know

Urinary tract infection Yes No Don't Know

Significant injury Yes No Don't Know

Ongoing medical treatment for _____ Yes No Don't Know

Do you have worries about possible problems with your child's

Hearing Yes No Bowel habits Yes No

Eyes Yes No Development Yes No

Heart Yes No Progress in school Yes No

Frequent cough or stuffy nose Yes No Appetite Yes No

Nose bleeds Yes No Behavior Yes No

Urination (e.g. bedwetting, goes too often, etc.) Yes No

Other concerns you would like to discuss? Yes No

Specify _____

Is your child on a special diet? Yes No

If so, what kind? _____

If your child is old enough to attend school, how many days did he/she miss during last year? _____

Do you think your child is basically healthy? Yes No

During the past 5 months has your child

Had frequent nightmares Yes No Not Applicable

Been difficult to control Yes No Not Applicable

Been fighting a lot Yes No Not Applicable

Had trouble making friends Yes No Not Applicable

Had trouble at school Yes No Not Applicable

FAMILY HISTORY

Date: _____

Circle any condition that your child’s close blood relatives have had (brothers, sisters, parents, aunts, uncles, cousins, grandparents) and include who had the condition.

- | | |
|--|---|
| Glaucoma | Colitis |
| Blindness | Intestinal polyps |
| Lazy eye (strabismus) | Thyroid problems |
| Cataracts | Diabetes |
| Wears glasses | Cancer before the age of 60
(specify type of cancer) |
| Cystic Fibrosis | Asthma |
| Tuberculosis | Congenital hip problems |
| High cholesterol | Arthritis (other than old age/overuse) |
| Hay fever | Learning problems |
| Eczema | Hyperactivity/ADD |
| Heart attacks at less than 50 years of age | Seizures |
| High blood pressure | Mental retardation |
| Heart problems they were born with | Emotional problems |
| Urine infections | Sudden death |
| Kidney disease | Death shortly after birth |
| Kidney stones | Melanoma/Skin cancer |
| Gallstones | Smoking cigarettes/cigars |
| Jaundice | Overuse of alcohol/drugs |
| Sickle cell disease | |
| Anemia or other blood problems | |

Other problems you want me to know about:

Parental weight/height:
