

WELCOME TO OUR PRACTICE

Today's Date _____

Mother's Name _____ Age _____
Father's Name _____ Age _____
Occupation: Mother _____ Father _____

Patient's Name _____
Date of Birth _____

If adults in the household work outside the home, what child care arrangements are made for this child?

A. Pregnancy & Birth

1. Mother's age when child was born _____
 2. Did mother have any illnesses during pregnancy? No Yes
 3. Did she take any medications other than vitamins and iron? No Yes
 4. Was the baby on time? No Yes
 5. Did the baby have any trouble at birth or while in the hospital? (e.g., jaundice, infections) No Yes
 6. Baby's birthweight _____
- Explain any Yes answers:

B. Past Medical History

1. Where has your child gone for check-ups before?

 2. Date of last checkup: _____
 3. Has your child had allergic reactions to any medications, foods, or insects? No Yes
 4. Any hospitalizations other than for birth? No Yes
 5. Any serious injuries? No Yes
 6. Any ongoing medical problems (e.g., asthma/ADD)? No Yes
 7. Are any medications taken regularly? No Yes
- Explain any Yes answers:

C. Family History

1. Circle any of the diseases below that this child's blood-related relatives have had. Include: mother (M), father (F), grandparents (GP), brothers/sisters (B or S), aunts/uncles (A or U)

Disease	Affected	Member(s)	Disease	Affected	Member(s)	Disease	Affected	Member(s)
AIDS	_____		Diabetes	_____		High Blood		
Allergies	_____		Drug/Alcohol			Pressure	_____	
Anemia	_____		Problems	_____		Mental		
Asthma	_____		Heart Prob.	_____		Illness	_____	
Cancer	_____		Genetic Disease	_____		Tuberculosis	_____	
Early Death (before age 40; including SIDS)	_____					High Cholesterol	_____	

Notes: _____

D. Feeding and Nutrition

1. Is your child's appetite usually good? No Yes
2. Was there severe colic or unusual feeding problems in the first 3 months? No Yes
3. Was he/she breast or bottle fed for the first six months? Breast Bottle Both

E. Review of Systems

1. Has your child had frequent ear infections? No Yes
 2. Does your child have any eye problems? No Yes
 3. Frequent headaches? No Yes
 4. Frequent colds or sore throat? No Yes
 5. Any asthma, pneumonia, or recurrent cough? No Yes
 6. Ever had a heart murmur or heart problem? No Yes
 7. Any recurrent diarrhea or constipation? No Yes
 8. Any problems with urination? No Yes
 9. Any seizures or nervous system problems? No Yes
 10. Any eczema, hives, or other skin problems? No Yes
 11. Has your child ever been anemic? No Yes
 12. Any orthopedic (bone or muscle) problems (e.g., scoliosis, foot problems, etc.)? No Yes
 13. Any other medical problems? _____
- _____

F. Development/Behavior

1. At what age did your child walk alone? _____
2. Approximately how many words did he/she say by 18 months of age? _____
3. How does this child compare with others his/her age? _____
4. What grade is he/she in? _____
5. Any problems sleeping? No Yes
6. Does he/she get along with other children? No Yes
7. Has this child had trouble in school? No Yes
8. Circle if your child has had any of the following:
nail biting, thumb sucking, bed wetting, nightmares, bad temper, hyperactivity, problems with discipline, speech problems, problems with toilet training, speech problems, other problems

G. Environment/Safety

1. Do you live in a private house, townhouse, mobile home, apartment, other? (Circle one)
2. Do you know the hottest temperature of the water in your pipes (should be 120 degrees or less)? No Yes
3. Is there a working smoke alarm on each floor of your home? No Yes
4. Does your child always use a car seat/seat belt when riding in a car? No Yes
5. Are there any smokers in your home? No Yes
6. Are there any problems with the condition of your home (peeling paint, insects, rats, or mice)? No Yes
7. Approximate age of your home/apartment? _____
8. Does your child always wear a helmet when riding a bicycle? No Yes

H. Spirituality

1. Does your family attend religious services regularly? No Yes
2. Do you pray with your child? No Yes
3. How important is God to you & your family? _____