Reviewed By: _____ Date: _____

PATIENT HISTORY

NAME_____ Male ☐ Female ☐

First *Middle* *Last* Race_____

Name child is called by_____ Birthdate_____

Where was the child born?_____ Obstetrician_____

Is child adopted?_____ At what age?_____ Is child aware?_____

Full term pregnancy?_____ Premature?_____ Type of delivery?_____

Mother: Have you had breast surgery?_____

Did you take hormones or medicines during pregnancy?_____

Do you or the father have any history of S.T.D. (herpes, HIV, group B strep, etc.)?_____

Problems at birth or in first few weeks?_____

Birth wt._____ Length_____ Head Circ._____ Apgar_____

Is your child taking medication now?_____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY

Rubella (German measles)_____

Chicken pox Disease_____ Vaccine_____

Strep Throats_____ Ear infections_____

Pneumonia_____

Convulsions / Seizures_____

Urinary infections_____

Bedwetting/soiling problem after age 5?_____

Asthma_____

Allergic to any medication?_____

Allergic to any food or insects?_____

Any smokers at home?_____ Any pets?_____

Is he/she receiving allergy shots?_____

Heart disease?_____ A heart murmur?_____

Meningitis?_____

Has child received blood transfusions or blood products?_____

Any orthopedic (bone, joint, muscle) problems?_____

School Problems / Performance:

Scholastic_____

Conduct_____

Has child had a learning problem?_____

Has child had a special class?_____

Disabilities?_____

Any other past illnesses?_____

OPERATIONS/HOSPITALIZATIONS (Include dates)

Circumcision_____

Tonsils and Adenoids_____

Appendectomy_____

Ear Tubes_____

Other operation or hospitalization_____

FAMILY HISTORY

	BIRTH DATE	HT.	WT.	EDUCATION LEVEL
MOTHER				
FATHER				

Has there been a separation, divorce or death?_____ When?_____

Who is legal guardian?_____ With whom does child live?_____

Has there been a remarriage?_____ What has been the attitude of your child to the situation?_____