

Name of Patient _____ DOB _____ Chart No. _____ Sex M F
 E-Mail Address _____ Race _____

ALLERGIES

Is your child allergic to any medications? yes no

Name of medication(s) and type(s) of reaction _____

Does your child have any environmental or food allergies? yes no

Please list allergen and type of reaction _____

Is your child allergic to eggs? yes no Type of reaction _____

Has your child been prescribed an Epi-pen for a severe allergic reaction? yes no

FAMILY HISTORY

Has anyone in your family had: (Include parent, grandparent, aunts, and uncles)

Please specify Maternal (mothers) Paternal (fathers)

Illness		Relationship	Illness		Relationship
High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no		Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no	
Heart Attack at age < 60	<input type="checkbox"/> yes <input type="checkbox"/> no		Sickle Cell Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no		Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	
Stroke at age < 60	<input type="checkbox"/> yes <input type="checkbox"/> no		Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no	
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no		Mental Illness	<input type="checkbox"/> yes <input type="checkbox"/> no	
Thyroid Problems	<input type="checkbox"/> yes <input type="checkbox"/> no		Migraine Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	
Allergic Disorders (Hay fever, Eczema)	<input type="checkbox"/> yes <input type="checkbox"/> no		Other	<input type="checkbox"/> yes <input type="checkbox"/> no	

PAST MEDICAL HISTORY

Check box if your child has or has had any of the following:

- Attention Deficit Disorder? yes no
- Asthma? yes no
- Frequent wheezing or coughing spell? yes no
- Urinary Tract Infections? yes no
- Recurrent or Frequent Ear Infections? yes no
- Recurrent or Frequent Strep Throat? yes no
- Heart Murmur? yes no

Other Significant Medical Conditions? _____

Hospitalizations? Please describe _____

Ear Tube Replacement? yes no If yes, what age? _____

Tonsillectomy or Adenoidectomy? yes no If yes, what age? _____

Other Surgeries? _____

Serious Injuries? _____

Serious reactions to Immunizations? yes no If yes, which immunization and type of reaction? _____

Prematurity or complications at birth? yes no Please describe _____

SOCIAL HISTORY

Do you have Pets? yes no What kind? _____

Do you have city water well water (check one)?

Are there any smokers in the home? yes no

Is your child in daycare (if under age 5)? yes no

Is your child home schooled? yes no

Name and ages of persons living with patient? _____

MEDICATIONS

What medications and dosages is your child on?	MEDICATION	DOSAGE	TIMES A DAY
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PREGNANCY AND BIRTH HISTORY

(only need to fill out if child is less than 3 months old)

How many weeks pregnant was mother when child was born? _____

Was mother Group b strep positive? yes no

If yes, did mother receive antibiotics? yes no

How many hours prior to delivery did mother membranes rupture? _____

Were there any complications with pregnancy or delivery? yes no

If yes, please explain _____

Was mother on medications other than prenatal vitamins? yes no

If yes, please list _____

Type of delivery c-section vaginal Name of Hospital _____

If C-section, give reason for c-section _____

At birth, what was your baby's weight? _____

Was your child in breech position anytime during pregnancy? yes no

Was your baby bottle-fed breast fed or both

Did your child have a hearing screen at birth? yes no don't know

If yes, results were normal abnormal

Name of person completing form _____

Relation to child _____ Date _____

Physician Signature _____ Date _____