First, print out this form. Fill it out. Bring it with you to our office.

Patient Name _____ DOB _____

Place of birth: _____

Pregnancy & Birth

Maternal illness during pregnancy or early labor? If "yes", list: _____
Was the baby born <37 or >41 wks gestation? If "yes", the baby was born at _____ weeks
What was the birth weight? _____
What type of delivery (check)

___ Vaginal ___ ceasarian ___ vacuum ___ forcep

Did the baby have trouble while in the hospital? If "yes", list: _____
(infection, jaundice, breathing difficulties, NICU) _____

Vaccination Status (please circle): Up-to-date **Delayed** **Not Immunized**
if delayed or not immunized explain:_____

Past Medical History (refers to child)

Any allergic reactions to medications, foods, insect stings, or immunizations? If "yes", which ones? _____
_____
Any overnight hospitalizations? If "yes", why and at what age? _____
Any surgeries? If "yes", what kind, at what age? _____
Any serious injuries? If "yes", what kind, at what age? _____
Any medications taken regularly? If "yes", which ones? _____
(other than cold medicines/pain relievers)

Check any medical problems your child has had:

- ☐ Urinary Tract Infections
- ☐ Asthma
- ☐ Frequent Strep Throat
- ☐ Frequent Ear Infections
- ☐ Learning Disability
- ☐ Anemia
- ☐ Heart Problems
- ☐ Vision/Hearing Problems
- ☐ Environmental Allergies
- ☐ Seizures
- ☐ ADHD
- ☐ Emotional/Behavior Problems
- ☐ Speech Problems
- ☐ Constipation
- ☐ Eczema

List any other medical problems your child has had that are not listed above _____
_____

Family History

Check any diseases that the child's **parents** or **siblings** have had and indicate who had it:

- ☐ Asthma
- ☐ Allergies
- ☐ Diabetes
- ☐ Seizures
- ☐ Hypertension
- ☐ Heart disease before age 50
- ☐ High cholesterol
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Kidney stones
- ☐ Mental Illness
- ☐ Thyroid
- ☐ Sudden unexplained death
- ☐ Genetic/inherited illnesses

List any other significant chronic illnesses in the family _____