Name _____ Sex _____ Birth Date _____ Today's Date _____
Mother's Name _____ Home Phone _____ Work Phone _____
Address _____ City _____ Zip _____
Father's Name _____ Home Phone _____ Work Phone _____
Address _____ City _____ Zip _____
Other numbers: Mom's cell _____ Dad's cell _____ Emergency _____

Household

Please list all people living in the child's home:

Name	Relationship to child	DOB	Health problems

Are there any siblings not listed here? List names and ages:

_____

_____

If parents not living together or if child does not live with parents, what is child's custody status?

_____

Is child in daycare? o Yes o No _____

Does anyone in the home smoke? o Yes o No

Birth History

Birth Hospital _____ Was the delivery Vaginal? _____ C-Section? _____ Reason if C-Section _____
Was the baby born at term? _____ Early? _____ Late? _____ Number of weeks? _____ Birth Weight _____
Problems with pregnancy? _____ Initial feeding _____ Breast _____ Bottle
Problems with baby? _____ Type of formula _____

Past Medical History for Child (provide any explanation in area provided)

Good health ☐ Yes ☐ No _____
Serious illness or medical condition ☐ Yes ☐ No _____
Hospitalization ☐ Yes ☐ No _____
Surgery ☐ Yes ☐ No _____
Drug Allergies: _____

Chicken Pox	☐ Yes	☐ No	Heart problem or murmur	☐ Yes	☐ No
Problems with hearing	☐ Yes	☐ No	Problems with eyes or vision	☐ Yes	☐ No
Asthma, bronchiolitis, bronchitis, or pneumonia	☐ Yes	☐ No	Anemia or bleeding	☐ Yes	☐ No
Frequent ear infections	☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No
Nasal allergies	☐ Yes	☐ No	Frequent abdominal pain	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Bladder or kidney infection	☐ Yes	☐ No
Bed wetting (after age 6)	☐ Yes	☐ No	Skin problems	☐ Yes	☐ No
Seizures or convulsions	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Thyroid or endocrine problems	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No
Girls only - Started menstrual periods	☐ Yes	☐ No	Girls only - Problems with periods	☐ Yes	☐ No

Explain

_____

_____

_____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No
Are you concerned about your child's emotional development? ☐ Yes ☐ No
Are you concerned about your child's attention span? ☐ Yes ☐ No
School concerns: _____

Family History (Parents, Grandparents, Brothers, Sisters, Aunts and Uncles of Child)

Deafness	☐ Yes	☐ No	Nasal allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart disease (before age 50)	☐ Yes	☐ No	High blood pressure (before age 50)	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Epilepsy or convulsions	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Drug abuse	☐ Yes	☐ No	Mental illness	☐ Yes	☐ No
Mental retardation	☐ Yes	☐ No	Immune problems, HIV, AIDS	☐ Yes	☐ No

Additional family history or explanation:

_____

_____