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**CHILD’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_ AGE:\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSON COMPLETING FORM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO CHILD:\_\_\_\_\_\_\_\_\_**

**CHILD’S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT HEALTH CONCERNS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICINES/VITAMINS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREGNANCY & BIRTH**

 Is this child yours by: \_\_\_ birth \_\_\_ adoption \_\_\_ stepchild \_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please indicate any medical problems during pregnancy \_\_\_ none \_\_\_ specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Delivery by: \_\_\_ vaginal birth \_\_\_ caesarian If caesarian, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Birth weight: \_\_\_\_\_\_\_\_\_\_ Birth length: \_\_\_\_\_\_\_\_\_\_\_\_\_ APGAR score 1 min:\_\_\_\_\_\_\_\_\_\_\_\_\_ 5 min. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please indicate any medical problems during the baby’s newborn period \_\_\_ none If premature, how early?\_\_\_\_\_\_\_

 Other problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NURTITION & FEEDING**

 Was your child breastfed? \_\_\_ No \_\_\_ Yes If so, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has your child had any unusual feeding/dietary problems? \_\_\_ No \_\_\_ Yes If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Milk intake now: Type \_\_\_ cow milk (\_\_\_\_ non-fat \_\_\_1% \_\_\_ 2% \_\_\_ whole milk) \_\_\_ soy milk \_\_\_ rice milk

 Average ounces per day (Note: 8 ounces are in 1 cup) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP**

 Hours per night \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Naps (number & length) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any sleep problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENT**

 At what age did your child: sit alone \_\_\_\_\_\_\_ walk alone \_\_\_\_\_\_\_ say words \_\_\_\_\_\_\_ toilet train (daytime) \_\_\_\_\_\_\_

 Girls only: Age at first menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY:** Has child been seen by a dentist? \_\_\_ No \_\_\_ Yes If so, how often \_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_

 **IMMUNIZATIONS/INFECTIOUS DESEASES**: Please bring your child’s immunization records to your appointment.

 Has your child had: \_\_\_ chickenpox \_\_\_ measles \_\_\_ mumps \_\_\_ rubella \_\_\_ meningitis \_\_\_ tuberculosis (TB)

**EXPOSURES/HABITS**: Any concerns about lead exposure? (old home/plumbing/peeling paint) \_\_\_ No \_\_\_ Yes

 Do any household members smoke? \_\_\_ No \_\_\_ Yes

 TV – hours per day \_\_\_\_\_\_\_\_\_ Computer – hours per day \_\_\_\_\_\_\_\_ Video Games – hours per day \_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**: Please describe any major medical problems and their dates

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hospitalizations/Operations (with dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**: Please circle any family history of the following (indicate who has/had the condition):

|  |  |  |
| --- | --- | --- |
| Alcoholism/drug abuse | Heart disease or stroke before age 60 | Seizures |
| Psychiatric disorders | Thyroid disease | Kidney disease |
| High blood pressure | Bleeding/clotting problems | Birth defects |
| Asthma/hayfever/eczema | Inherited/genetic diseases |  |

**SOCIAL HISTORY**:

 Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current (or upcoming) grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Who lives at home?

 Name Age Relationship Highest Education Level

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Are the child’s parents \_\_\_ married \_\_\_ unmarried \_\_\_ separated \_\_\_ divorced If divorced, when? \_\_\_\_\_\_\_\_\_\_

Parents’ occupations: Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Care Situation \_\_\_\_\_Parents \_\_\_ others (specify who and hours per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Concerns about your child: \_\_\_ Alcohol use \_\_\_ Tobacco \_\_\_ Sexual Activity \_\_\_ Aggressive Behavior

Is violence at home a concern? \_\_\_ No \_\_\_ Yes Are there guns in the home? \_\_\_ No \_\_\_ Yes

**SCHOOL HISTORY**:

 Did/does your child attend preschool? \_\_\_ No \_\_\_ Yes Current grade \_\_\_\_\_\_\_\_ Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any concerns about school performance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any concerns about relationships with: Teachers \_\_\_ No \_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Students \_\_\_ No \_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If over 4 years old, does your child have a best friend? \_\_\_ No \_\_\_ Yes

 Sports / exercise: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long (minutes) \_\_\_\_\_\_\_\_\_\_

**REVIEW OF ORGAN SYSTEMS:** If child has more than one symptom on a line, circle the relevant one(s).

 Constitutional/Endocrine Gastrointestinal Allergy

\_\_\_Fevers/chills/excessive sweating \_\_\_Nausea/vomiting/diarrhea \_\_\_Havfever/itchy eyes

 \_\_\_Unexplained weight loss/ gain \_\_\_Constipation Skin

 Eyes \_\_\_Blood in bowel movement \_\_\_Rashes

 \_\_\_Squinting/”crossed” eyes/ Cardiovascular \_\_\_Unusual moles

 asymmetric gaze \_\_\_\_Tires easily with exertion Psychiatric/Emotional

 Ears/Nose/Throat \_\_\_Shortness of breath \_\_\_Speech Problems

 \_\_\_Unusually loud voice/hard of \_\_\_Fainting \_\_\_Anxiety/stress

 hearing Genitourinary \_\_\_Problems with sleep/

 \_\_\_Mouth breathing/snoring \_\_\_Bedwetting nightmares

 \_\_\_Bad breath \_\_\_Pain with urination \_\_\_Depression

 \_\_\_Frequent runny nose \_\_\_Discharge: penis or vagina \_\_\_Nail biting/thumbsucking

\_\_\_Problems with teeth/gums Neurological \_\_\_Bad temper breath-

Respiratory \_\_\_Headaches holding / jealousy

\_\_\_Cough/wheeze \_\_\_Weakness Blood/Lymph

 \_\_\_Clumsiness \_\_\_Unexplained lumps

 Muscular/Skeletal \_\_\_Easy bruising/bleeding

 \_\_\_Muscle/joint pain