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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:**______________________________________________________________
__________________________________________________________________________________________
**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: ________________________________________________________________________________
_______________________________________________________________________________________

**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

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Hospitalizations/Operations (with dates):_____________________________________________________________
__________________________________________________________________________________________
Broke bones or severe sprains _____________________________________________________________________

**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 |
|---|---|---|---|
| ___________________________ | _________ | ________________________ | ___________________________ |
| ___________________________ | _________ | ________________________ | ___________________________ |
| ___________________________ | _________ | ________________________ | ___________________________ |
| ___________________________ | _________ | ________________________ | ___________________________ |
| ___________________________ | _________ | ________________________ | ___________________________ |
| ___________________________ | _________ | ________________________ | ___________________________ |

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) ________________________

____________________________________________________________________________________________________

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
___Fevers/chills/excessive sweating
___Unexplained weight loss/ gain

Eyes
___Squinting/"crossed" eyes/ asymmetric gaze

Ears/Nose/Throat
___Unusually loud voice/hard of hearing
___Mouth breathing/snoring
___Bad breath
___Frequent runny nose
___Problems with teeth/gums

Respiratory
___Cough/wheeze

Gastrointestinal
___Nausea/vomiting/diarrhea
___Constipation
___Blood in bowel movement

Cardiovascular
____Tires easily with exertion
___Shortness of breath
___Fainting

Genitourinary
___Bedwetting
___Pain with urination
___Discharge: penis or vagina

Neurological
___Headaches
___Weakness
___Clumsiness

Muscular/Skeletal
___Muscle/joint pain

Allergy
___Havfever/itchy eyes

Skin
___Rashes
___Unusual moles

Psychiatric/Emotional
___Speech Problems
___Anxiety/stress
___Problems with sleep/ nightmares
___Depression
___Nail biting/thumbsucking
___Bad temper breath-holding / jealousy

Blood/Lymph
___Unexplained lumps
___Easy bruising/bleeding