WELCOME TO OUR PRACTICE	Patient Name		
Form Completed By/Relationship to Patient	Birth Date	Age	
Today's Date	Male	Female	
Patient Social Security Number	Home Phone Number		
Primary Address	City	State	Zip
Mother Cell Number / Father Cell Number		Mother Work Number / Father Work Number	
Email Address	Fax Number		
Referred By			

HOUSEHOLD

Please list all those living in the child's house

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names ages and where they live_____

_____

If mother and father are not living together, or if child does not live with parent, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home? _____

_____

BIRTH HISTORY

Birth Weight_____ lbs _____oz.
Was the baby born at term? □ Yes □ No □ Early □ Late
If early, how many weeks gestation? _____
Did mother have any illness or problem with her pregnancy?
□ Yes □ No Explain _____
During pregnancy, did mother: Smoke □ Yes □ No
Use drugs or medications □ Yes □ No
What_____When_____

Was the delivery □ Vaginal or □ Cesarean?
If cesarean, why? _____
Did your baby have any problems right after birth?
□Yes □ No Explain_____

_____
Was initial feeding □ Breast or □ Bottle?
Did your baby go home with mother from the hospital?
□Yes □ No Explain_____

_____

GENERAL

Do you consider your child to be in good health? □ Yes □ No Explain_____
Does your child have any serious illness or medical condition? □ Yes □ No Explain_____
Has your child had any serious injuries or accidents? □ Yes □ No Explain_____
Had your child had any surgery? □ Yes □ No Explain_____
Has your child ever been hospitalized? □ Yes □ No Explain_____
Is your child allergic to any medicine or drugs? □ Yes □ No Explain_____
Is your child allergic to any foods? □ Yes □ No Explain_____

DEVELOPMENT

Are you concerned about your child's physical development? □ Yes □ No Explain_____
Are you concerned about your child's mental or emotional development? □ Yes □ No Explain_____
Are you concerned about your child's attention span? □ Yes □ No Explain_____

If your child is in school:
What Grade?_____
Name of School:_____
How is his/her behavior in school?_____
Has he/she failed or repeated a grade in school? _____
How is he/she doing in academic subjects?_____
Is he/she in special or resources classes?_____

FAMILY HISTORY

Have any family members had the following:

Deafness	□ Yes □ No	Who_____	Comments_____
Nasal allergies	□ Yes □ No	Who_____	Comments_____
Asthma	□ Yes □ No	Who_____	Comments_____
Tuberculosis	□ Yes □ No	Who_____	Comments_____
Heart disease or Stroke (before age 50)	□ Yes □ No	Who_____	Comments_____
High blood pressure (before age 50)	□ Yes □ No	Who_____	Comments_____
High cholesterol	□ Yes □ No	Who_____	Comments_____
Anemia	□ Yes □ No	Who_____	Comments_____
Bleeding disorder	□ Yes □ No	Who_____	Comments_____
Liver disease	□ Yes □ No	Who_____	Comments_____
Kidney disease	□ Yes □ No	Who_____	Comments_____
Diabetes (before 50 years old)	□ Yes □ No	Who_____	Comments_____
Cancer (indicate type and age of onset)			
Obesity			
Bed wetting (after 10 years old)	□ Yes □ No	Who_____	Comments_____
Epilepsy or convulsions	□ Yes □ No	Who_____	Comments_____
Alcohol or drug abuse	□ Yes □ No	Who_____	Comments_____
Death before 50 years old	□ Yes □ No	Who_____	Comments_____
Mental illness	□ Yes □ No	Who_____	Comments_____
Developmental Delays	□ Yes □ No	Who_____	Comments_____
Immune problems, HIV/AIDS	□ Yes □ No	Who_____	Comments_____

Additional family history _____
_____
_____

PAST HISTORY

Does your child have or has he/she ever had:

Chickenpox	□ Yes □ No	When_____
Frequent ear infections	□ Yes □ No	Explain _____
Problems with ears or hearing	□ Yes □ No	Explain _____
Nasal allergies	□ Yes □ No	Explain _____
Problems with eyes or vision	□ Yes □ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	□ Yes □ No	Explain _____
Any heart problem or heart murmur	□ Yes □ No	Explain _____
Anemia or bleeding problem	□ Yes □ No	Explain _____

Blood transfusion	□ Yes □ No	Explain _____
Frequent abdominal pain	□ Yes □ No	Explain _____
Constipation requiring doctor visits	□ Yes □ No	Explain _____
Bladder or kidney infections	□ Yes □ No	Explain _____
Bed wetting (after 5 years old)	□ Yes □ No	Explain _____
(For girls) Has she started her menstrual period	□ Yes □ No	When _____
(For girls) Are there problems with her periods?	□ Yes □ No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	□ Yes □ No	Explain _____
Frequent headaches	□ Yes □ No	Explain _____
Convulsions or other neurologic problems	□ Yes □ No	Explain _____
Diabetes	□ Yes □ No	Explain _____
Thyroid or other endocrine problems	□ Yes □ No	Explain _____
Any other significant problems	□ Yes □ No	Explain _____
Use alcohol or drugs	□ Yes □ No	Explain _____

Is your child on any current medications? □ Yes □ No

If Yes, please list: _____

_____

_____

Other Medical Specialists

Please list any other medical specialists that your child sees

Name	Type of Specialty

Authorization For Treatment

In the event that I, (name of parent/guardian)_____ am unable to accompany my child/children listed above, I authorize the following individual(s) to give permission for minor treatments in my absence:

Name	Relationship

Emergency Contact Information

Name_____

Relationship to Child_____

Phone Number Best to Be Reached at_____

PHARMACY INFORMATION

Pharmacy Name_____

Address_____

Phone Number_____

INSURANCE INFORMATION

Name of Insurance_____ ID#_____ GRP#_____

Policy Holder Name_____

Employer_____

Employer Address_____

CURRENT PEDIATRICIAN_____ **TELEPHONE**_____