General Information

Patient's full name:_____

Patient's date of birth:_____

Nickname:_____

Patient's previous doctor:_____

(Optional) Race:_____

Ethnicity: ☐Hispanic ☐Non Hispanic

Current medications

Please include vitamins, supplements and herbs:

_____

_____

Allergies

☐ None

☐ Food:_____

☐ Seasonal:_____

☐ Other:_____

Pregnancy and Delivery

Where was patient born? (State and hospital): _____

_____

Is the patient yours by:

☐ Birth ☐ Adoption

☐ Stepchild ☐ Foster child

☐ Other_____

Pregnancy:

Any medications taken during pregnancy:

☐ None ☐ Prenatal vitamins

☐ Other_____

_____

Please indicate any complications during pregnancy:

☐_____

_____

Delivery:

☐ Vaginal ☐ Caesarian Section ☐ Breech

Birth weight:_____Birth length:_____

☐ Premature & how early?_____

Please indicate any delivery complications including NICU if relevant:_____

_____

_____

_____

Immunizations ******Please bring a copy of your immunization record to your first appointment, or send it by mail or fax with this form.**

☐ Immunizations current

☐ Behind on immunizations & why:_____

_____

☐ Not immunized & why:_____

_____

Family Social History

Who lives at home with patient? (Include parents, siblings, grandparents, etc.)

Household #1

Name Age Relationship

_____

_____

_____

_____

_____

Household #2

Name Age Relationship

_____

_____

_____

_____

_____

If patient spends time in two households, describe custody arrangements (50/50, etc): _____

_____

_____

Parent #1 occupation:_____

Parent #1 employer:_____

Parent #2 occupation:_____

Parent #2 employer:_____

Past Medical History

☐ Current or previous medical diagnoses:_____

_____

_____

☐ Hospitalizations & why? (Include age or date):___

_____

_____

☐ Surgeries & why? (Include age or date):_____

_____

_____

☐ Injuries, concussions, fractures, stitches, etc:_____

_____

Development:

Have you or a previous provider had concerns regarding your child's development (speech, gross motor, fine motor, etc)? ☐ Yes ☐ No

If Yes, please describe:_____

_____

_____

Have you or a previous provider had concerns regarding your child's puberty timing (early or late)?

☐ Yes ☐ No

If Yes, please describe:_____

_____

_____

Has your child started menstruating (period)?

☐ Yes ☐ No ☐ N/A

Nutrition:

☐ Eats a well-balanced diet ☐ Vegetarian

☐ Vegan ☐ Picky eating or nutritional concerns

Has your child had any dietary or feeding problems? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Sleep:

Hours per night:_____

Any sleep problems?_____

_____

Dental:

Is the patient seeing a dentist? ☐ Yes ☐ No

Dental problems or concerns:_____

_____

School:

Current school:_____

Grade level:_____

Any concerns about school performance?

☐ Yes ☐ No If yes, please explain:_____

_____

_____

Mental Health:

Have you or a previous provider had concerns regarding your child's behavior/emotional needs?

☐ Yes ☐ No

If Yes, please describe:_____

_____

_____

If Yes, has your child had any evaluations or therapy?_____

_____

Activities/Exposures/Habits:

☐ Physical Activity:_____

_____

☐ Other activities:_____

Number of hours per day of screen time (TV, computers, video games, etc.):_____

Any family members smoke (inside or outside)?

☐ Yes ☐ No

Firearms in the home? ☐ Yes ☐ No

If yes, are locked? ☐ Yes ☐ No

Review of All Systems: Please check any current or past medical problems your child has had.

General:

- ☐ Fever
- ☐ Excessive sweating
- ☐ Chills
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Unexplained weight gain

Eyes:

- ☐ Wears glasses
- ☐ Wears contacts
- ☐ Lazy eye(s)
- ☐ Crossed eyes

Ears, Nose & Throat:

- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Allergies
- ☐ Frequent runny nose
- ☐ Snoring
- ☐ Frequent bloody nose
- ☐ Frequent sore throats or strep throat
- ☐ Problems with teeth and gums

Respiratory:

- ☐ Asthma
- ☐ Chronic cough
- ☐ RAD or wheezing
- ☐ Chest pain
- ☐ Recurrent croup
- ☐ EIB
- ☐ Shortness of breath with exercise

Cardiovascular:

- ☐ Heart murmur
- ☐ Heart defect
- ☐ Fainting
- ☐ Arrhythmia
- ☐ Poor endurance compared to peers

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Unexplained vomiting
- ☐ Blood in stools
- ☐ Frequent stomachaches
- ☐ Jaundice
- ☐ Soiling underwear

Genitourinary:

- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ UTI
- ☐ Urinary reflux
- ☐ Painful periods
- ☐ Irregular periods
- ☐ PMS

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Head injuries
- ☐ Concussions - If so, indicate the #_____

Neurological:

- ☐ Tension headaches
- ☐ Dizziness
- ☐ Migraine headaches
- ☐ Fainting
- ☐ Seizures
- ☐ Staring spells

Psychiatric, Emotional & Education:

- ☐ ADD/ADHD
- ☐ Developmental delays
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Aggression/Fighting
- ☐ Speech problems
- ☐ Sleep difficulty
- ☐ IEP
- ☐ Learning difficulty
- ☐ Substance abuse

Skin:

- ☐ Eczema
- ☐ Acne
- ☐ Unusual moles
- ☐ Rashes
- ☐ Hives
- ☐ Bruising

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Short stature
- ☐ Precocious puberty

Specific infections (Plus age or date of infection):

- ☐ Chicken pox_____ ☐ Meningitis_____
- ☐ RSV_____ ☐ Tuberculosis_____
- ☐ Whooping cough (Pertussis)_____

Any other concerns?_____

_____

_____

_____

_____

_____

_____

Family History: Please indicate using the following key any family members who at any time in their lives have been diagnosed with any of these conditions. Please indicate if any family members have died from any of these conditions.

KEY-PLEASE USE THE FOLLOWING IDENTIFIERS FOR FILLING OUT THE FAMILY HISTORY

Mother = Mother of Patient	**Brother** = Brother of Patient	**Grandfather** = Patient's Grandfather	**Aunt** = Mother or Father's Sister	**Cousin** = Cousin of Patient
Father = Father of Patient	**Sister** = Sister of Patient	**Grandmother** = Patient's Grandmother	**Uncle** = Mother or Father's Brother	

Mother's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
Educational difficulties_____
GI disorders (Reflux, Colitis, Crohn's)_____
Hearing loss_____
Heart disease_____
Heart arrhythmia (Prolonged QT, SVT)_____
High blood pressure_____
High cholesterol_____
Hip dysplasia_____
Kidney disease_____
Lazy eye (Strabismus)_____
Melanoma_____
Mental illness_____
Migraine headaches_____
Obesity/Overweight_____
Renal reflux_____
Rheumatological disease_____
Scoliosis_____
Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____

Father's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
Educational difficulties_____
GI disorders (Reflux, Colitis, Crohn's)_____
Hearing loss_____
Heart disease_____
Heart arrhythmia (Prolonged QT, SVT)_____
High blood pressure_____
High cholesterol_____
Hip dysplasia_____
Kidney disease_____
Lazy eye (Strabismus)_____
Melanoma_____
Mental illness_____
Migraine headaches_____
Obesity/Overweight_____
Renal reflux_____
Rheumatological disease_____
Scoliosis_____
Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____