



Medical History

Patient Name: _____ Date of Birth: _____

Birth History

Birth weight: _____

Premature? (Born before 37 weeks) Yes No
If yes, born at _____ weeks

Jaundice? Yes No
If yes, was treatment with lights required? Yes No

Passed infant hearing test (older children will not have had this test) Yes No

Describe any other problems during the newborn period: _____

Medication History

Does your child take any prescription or over-the-counter / herbal medications? Yes No

If yes, please list: _____

Allergies

Mark all that apply:

- | | |
|---|----------------------------------|
| <input type="radio"/> NONE | <input type="radio"/> Peanuts |
| <input type="radio"/> Penicillin (including Amoxicillin and Augmentin) | <input type="radio"/> Other nuts |
| <input type="radio"/> Cephalosporin (including Keflex/Omnicef/Duracef/Rocephin) | <input type="radio"/> Shellfish |
| <input type="radio"/> Latex | <input type="radio"/> Eggs |
| <input type="radio"/> Bee Stings | <input type="radio"/> Dairy |
| <input type="radio"/> Pollen | <input type="radio"/> Wheat |
| <input type="radio"/> Dust / dust mites | <input type="radio"/> Cats |
| <input type="radio"/> Mold | <input type="radio"/> Dogs |

Other allergies? Please list: _____

Medical History

Please mark all conditions that apply:

- | | | |
|---|--|--|
| <input type="radio"/> Asthma | <input type="radio"/> Autism | <input type="radio"/> ADD / ADHD |
| <input type="radio"/> Developmental Delay | <input type="radio"/> Gastric Reflux | <input type="radio"/> Ear infections |
| <input type="radio"/> Pneumonia | <input type="radio"/> Speech Delay | <input type="radio"/> Febrile Seizures |
| <input type="radio"/> Constipation | <input type="radio"/> Chronic Abdominal Pain | <input type="radio"/> Headache |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Sleep Problems |

Heart Murmur. Please describe any testing done: _____

Other? Please list: _____

Hospitalizations, Surgery or Major Injuries

Any hospitalizations? Yes No

List hospitalizations: _____

Surgery? Mark all that apply:

- NONE
- Ear tube placement Date: _____
- Tonsils Date: _____
- Adenoids Date: _____
- Appendicitis Date: _____

- Other? Please list: _____

List major injuries: _____

Family History

Please mark any conditions that exist in the patient's mom, dad, sibling(s) or grandparent(s):

- | | | | | | | | | |
|----------------------|-----------------------|-----|-----------------------|-----|-----------------------|------------|-----------------------|----------------|
| Asthma? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Allergies? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Eczema? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Autism? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| ADD / ADHD? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Developmental Delay? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Mental Retardation? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Celiac Disease? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Inflammatory Bowel? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Heart Defect? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |

Please list type: _____

- | | | | | | | | | |
|---------------------|-----------------------|-----|-----------------------|-----|-----------------------|------------|-----------------------|----------------|
| Heart Disease? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Diabetes? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Hypertension? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Kidney Disease? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Thyroid Disease? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Anxiety/Depression? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Alcoholism? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Seizure Disorder? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Migraine? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |
| Cancer? | <input type="radio"/> | Mom | <input type="radio"/> | Dad | <input type="radio"/> | Sibling(s) | <input type="radio"/> | Grandparent(s) |

Please list type: _____

Other Family History? Please list: _____

Social History

- | | | | | | | |
|-----------------------------------|-----------------------|-----|-----------------------|-------------|-----------------------|---------------|
| Smoke exposure at home? | <input type="radio"/> | No | <input type="radio"/> | Yes | | |
| Violence exposure at home? | <input type="radio"/> | No | <input type="radio"/> | Yes | | |
| School Concerns? | <input type="radio"/> | N/A | <input type="radio"/> | No | <input type="radio"/> | Yes |
| Travel Outside the United States? | <input type="radio"/> | No | <input type="radio"/> | No | <input type="radio"/> | Yes |
| Guns at home? | <input type="radio"/> | No | <input type="radio"/> | Yes, locked | <input type="radio"/> | Yes, unlocked |
| Daycare? | <input type="radio"/> | No | <input type="radio"/> | No | <input type="radio"/> | Yes |
| Pets at home? | <input type="radio"/> | No | <input type="radio"/> | No | <input type="radio"/> | Yes |