Patient History

CHILD'S NAME _____ DOB _____
Form completed by: _____ Relationship to the child: _____

BIRTH HISTORY

Birth Weight _____ Length _____ Place Of Birth _____
Preterm or Full Term _____ Vaginal or C-section delivery _____
Any complications during pregnancy or delivery? _____
How long did the baby stay in the hospital after birth? _____
Did he/she have any problems? (I.e. Jaundice, respiratory distress, infection)
_____

PAST MEDICAL HISTORY

Has the child ever had any problems with the following? If YES, please explain:

ADHD	YES _____	NO
Asthma/RAD	YES _____	NO
Allergies (food/environmental)	YES _____	NO
Anemia/Blood Disorders	YES _____	NO
Bones/Joints	YES _____	NO
Diabetes	YES _____	NO
Ears (multiple infections)/Hearing	YES _____	NO
Eyes/Vision	YES _____	NO
Gastrointestinal (GE reflux/ Constipation/diarrhea)	YES _____	NO
Heart	YES _____	NO
Repeated infections	YES _____	NO
Seizures/Headaches	YES _____	NO
Skin (eczema)	YES _____	NO
Urine/Kidneys	YES _____	NO
Other	_____	

Allergies to medicine YES _____ NO

Please list any hospitalizations, operations, serious illness or injuries with dates:
_____ Date: _____
_____ Date: _____

Please list any developmental problems or delays and when they occurred:
_____ Age: _____
_____ Age: _____

Immunizations up to date? YES ___ NO ___

Please list medications child is currently taking and reason:

Medication	Reason
_____	_____
_____	_____
_____	_____