



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
