

Name _____ DOB _____ Age _____ Sex M or F
Grade of School: _____
Address: _____
City: _____ State: _____ Zip: _____

Mother's Name and occupation: _____
Father's Name and occupation: _____
Parents are (circle): Married Separated Divorced Living Together Other

Regular Pediatrician name and city located in: _____
Reason for Office Visit: _____ Well Baby Check? Yes No _____
Has child been seen by any other doctor(s) for this complaint? Yes No

Has child had any blood work done? If yes, please list what:

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.
- 4.

Please list all medicines (from drugstore or prescription) child is on now:

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking:

- 1.
- 2.
- 3.
- 4.

Any known Allergies to food, drugs, environment, animals: _____

Previous Medical History

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes No Past
If has had, how many total? _____

Colds? Yes No Past
If has had, how many total? _____

Strep throat? Yes No Past
If has had, how many total? _____

How many times has the child taken antibiotics? _____

What other medicine has the child taken? And how often?

- 1.
- 2.
- 3.
- 4.

Hearing tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Any speech impediments:	Yes	No	Past
Learning impediments:	Yes	No	Don't know

Vaccination History: **Yes**, has had; **No**, has not; **Some**, did not finish all shots or on alternate schedule

Hep B	Yes	No	Some
RotaVirus	Yes	No	Some
DPT:	Yes	No	Some
Hib:	Yes	No	Some
Pneumococcal	Yes	No	Some
Polio (inactivated)	Yes	No	Some
Influenza	Yes	No	Some
MMR	Yes	No	Some
Varicella (chkpox)	Yes	No	Some
Hep A	Yes	No	Some
Meningococcal	Yes	No	Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History

Allergies: Yes No Obesity: Yes No
Cancer: Yes No Tuberculosis: Yes No
Cardiovascular disease: Yes No Mental Illness: Yes No
Diabetes mellitus: Yes No

Mother’s Pregnancy history

Age at conception: _____ Have other children already? Yes No

Health During Pregnancy:

Smoking: Yes No Diabetes: Yes No
Coffee: Yes No Nausea/Vomiting: Yes No
Recreational drugs: Yes No Emotional Stress: Yes No
Preeclampsia: Yes No Length of Labor: _____
Vaginal birth: Yes No Traumatic birth: Yes No

If the birth was difficult, please explain: _____

Health of baby at birth: _____

APGAR Score: _____

Child breastfed: Yes No For how long: _____
When put on formula: _____ What formula was used: _____
When was child put on solid food: _____
When did child Walk: _____ Talk: _____
Develop Teeth: _____

Health History of Child

Jaundice as baby: Yes No Colic: Yes No
Cradle cap: Yes No Anemia: Yes No
Eczema or psoriasis: Yes No Asthma: Yes No
Diarrhea: Yes No Warts: Yes No
Constipation: Yes No Nightmares: Yes No
Finicky eating: Yes No Bed-wetting: Yes No
Poor teeth: Yes No Tantrums: Yes No
Chronic sniffles: Yes No Disobedient: Yes No
Bad foot odor: Yes No Fears/Phobia: Yes No
Very sweaty baby/child: Yes No Diaper Rash: Yes No
Hyperactivity: Yes No Early Puberty: Yes No

Growing pains: Yes No Stomach aches: Yes No

Any particular household stressors child has witnessed or gone through:

- 1. _____
- 2. _____
- 3. _____

Known Allergies to Food, Medicines, Pollens, Dander, etc.: _____

Typical Day's Diet:

Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Supper: _____
Snack: _____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area? _____
Has the child ever lived in a house with lead paint? _____
Has the child ever lived in a house that had new paint, cabinets, carpeting, mattress installed and did that seem to affect their health at all? _____
Do you spray pesticides or herbicides around the house or use other toxic chemicals? _____
Does the child seem particularly sensitive to perfumes or other vapors? Yes No explain _____
