Patient History

Patient Name: _____ Date of Birth: _____

Parent/Guardian #1:	Parent/Guardian #2:
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Education/Training: _____	Education/Training: _____
Occupation: _____	Occupation: _____
Preferred Phone #: _____	Preferred Phone #: _____

Home Environment: Please list other family and household members:

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		

Please list any pets: _____

Are your child's parents: ___Married ___Unmarried ___Separated ___Divorced

If separated/divorced, what is the custody arrangement? _____

Child-care situation: __Parents __Others (specify who and hours per day) _____

Birth History:

Hospital where born: _____ City: _____ State: ___ Country: _____

Weight: _____Full Term or Premature (___ weeks) Complications of delivery: _____

Type of delivery: Vaginal or Cesarean If cesarean, why? _____

Complications of pregnancy: _____

Fertility/Assisted Birth___ Adoption___ Stepchild___ Other: _____

Breast Fed? Yes No How long? _____ Formula Fed? Yes No Which one(s)? _____

Medical History: (Check any that have been diagnosed and comment below)

__ Hospitalization	__ Congenital Heart Disease	__ Diabetes	__ Recurrent Ear Infections
__ Asthma	__ Prematurity	__ Vision Problems	__ Urinary Tract Infection (UTI)
__ Allergic Rhinitis	__ GE Reflux	__ Seizures	__ Vesicoureteral Reflux (VUR)
__ Eczema	__ Constipation	__ ADD/ADHD	
__ Wheezing	__ Anemia	__ Mental Illness	
__ Food Allergies	__ Murmur	__ Substance Abuse	

Other Medical History: _____

Please list current medications, vitamins, and supplements, even those used intermittently:

_____

Please list allergies or reactions to medications or foods:

Allergy:	Reaction:
_____	_____
_____	_____

Surgical History: (Check any past surgeries and complete age/date) ____No Surgeries

Procedure:	Age/Date:	Procedure:	Age/Date:	Other Surgeries:
__Adenoidectomy	_____	__Hernia Repair	_____	_____
__Appendectomy	_____	__Orthopedic Surgery	_____	_____
__Ear Tubes	_____	__Tonsillectomy	_____	_____
__Heart Surgery	_____	__Circumcision/Urological Surgery	_____	