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CHILD HISTORY/ PHYSICAL FORM

(children under 12)

PATIENT'S NAME ______________________________________ DOB ______________________________

Primary Care Physician ____

	Name	Age	State of Health
Parent #1	________________________________	___________	______________________________
Parent #2	________________________________	___________	______________________________
Sibling	________________________________	___________	______________________________
Sibling	________________________________	___________	______________________________
Sibling	________________________________	___________	______________________________
Sibling	________________________________	___________	______________________________

FAMILY HISTORY:

Allergies ________________________________ Heart Disease________________________________

Diabetes ________________________________ Seizure Disorders _____________________________

Mother's Blood Type ___________ RH_____ Child's Blood Type _____________

BIRTH AND DEVELOPMENT

Term pregnancy? ______________ Formula _________________ Vitamins ________________________

Soft food _____________________ Present Diet _________________ Feeding Habits _______________

Appetite _____________________ Likes _____________________ Dislikes ________________________

Vomiting ____________ Stools _______________ Sensitivity _______________ Hives _______________

ILLNESSES (circle)

Pertussis Measles Rubella Mumps Chickenpox Scarlet Fever

Diphtheria Operations Allergy Appendix T and A (tonsillectomy)

Colds Tonsillitis Diabetes Rheumatic Fever Otisis (Ear Infections)

Convulsions Constipation

OTHER: ____

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PARENT'S CONCERNS: ____

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