Patient Name: ______________________ DOB: ___________________________

We ask that you answer all the questions on this form to the best of your knowledge. It will help the doctor get an accurate history of your medical concerns and conditions. We really want to know you well so that we may provide the proper care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: ____

Other concerns:

____

____

Pharmacy: ____

MEDICATIONS:	DOSE:	START DATE:

Allergies to medications: (If yes, to what & what reactions)

____

BIRTH INFORMATION:

☐ Part of multiple birth

Apgars:	
Gestational age:	
Type of delivery:	
Hearing screen:	
Newborn screen:	
Birth weight:	
Birth length:	
Head Circumference:	
Birth place: (hospital & city)	

Patient Past Medical History

	YES	NO		YES	NO
Serious injuries or accidents			Emotional problems:		
Surgeries			Eye condition/glasses		
Hospitalizations			Problems with ears or hearing		
Chicken Pox			Anemia		
Frequent ear or sinus infections			Blood transfusion		
Pharyngitis/tonsillitis			Frequent headaches		
Other infections or illnesses			Seizures or developmental delays		
Allergic rhinitis/allergies			ADD/ADHD or other neurologic disease		
Animal allergies			Mental health concerns		
Outdoor allergies			Orthopedic problems		
Indoor allergies			Diabetes		
Asthma/bronchitis			Thyroid		
Heart problems/murmurs			Females: menstrual period start date: ___________		
Abdominal pain/GERD			Any period problems:		
Constipation			Any use of alcohol or drugs:		
Bladder/kidney infections			Other significant problems:		
Bed-wetting (after 5 years of age)					

Perinatal History

	YES	NO		YES	NO
Newborn screen reviewed			Circumcision		
Resuscitation at delivery			Delayed passage of meconium		
Preterm infant			Murmur		
Refusal of vitamin K/eye prophylaxis			Respiratory problems (TTN/RDS)		
Feeding: breast milk/formula			Oxygen		
Hypoglycemia			Assisted ventilation		
Hypothermia			Antibiotics		
Sepsis screening labs			Apnea		
Transcutaneous billirubin (TcB)			Head ultrasound		
Jaundice					

Maternal History

	YES	NO		YES	NO
Assisted conception			Problem with maternal health		
High risk pregnancy			Problem with fetus		
Amniocentesis/CVS			Prolonged rupture of membranes		
Absence of prenatal care			Antibiotics during labor		
Maternal use of alcohol			Induction of labor		
Maternal use of tobacco			C-Section		
Maternal use of drugs			Meconium at delivery		

Family History

	YES	NO	Family member
Cancer			
Diabetes			
High Cholestorl			
High blood pressure			
Heart problems/disease			
Kidney disease			
Other:			

Social History

	YES	NO		YES	NO
Family intact			Pets: list below		
Non-intact Custody status					
Siblings: list below					
			Smokers in the house		
			Guns in the home		
			Guns are locked & away from ammo		