Patient History

Childs Name: _____ DOB: _____/_____/_____
Form Completed by: _____ Relationship to the child_____
Birth Weight_____ Length _____ Place of Birth _____
Preterm or Full Term_____ Vaginal or C-Section Delivery_____
Were there 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/	Yes_____	No
Constipation/diarrhea)	Yes_____	No
Heart	Yes_____	No
Repeated infections	Yes_____	No
Seizures/Headaches	Yes_____	No
Skin (eczema)	Yes_____	No
Urine/Kidneys	Yes_____	No
Other	Yes_____	No
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:
_____Date:_____/_____/_____
_____Date:_____/_____/_____

Are the child's immunizations up to date? Yes_____ No_____

Please list medication child is currently taking and reason:

Medication:	Reason:
_____	_____
_____	_____
_____	_____