Please take time to fill out this form concerning your child's health.
Thank you for trusting us with your care.

Name_____ Date of Birth_____
Form Completed by_____ Date Completed_____
Relationship to patient_____
Preferred Pharmacy_____
Reason for Visit_____
Email address _____
Preferred method of communication:
□ Email □ Phone □ Mail

Visit: □ Birth □ 12months □ 24months □ 3 years □ 4 years □ 5 years □ 6 + years

Household

Parent 1 name _____ Age_____ Current health _____
Past health problems_____
Parent 2 name _____ Age_____ Current health _____
Past health problems_____
Marital status of parents _____ Child lives with _____

Other children in family: Name	Date of birth	Health problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History

□ Previously Completed □ Don't know birth history
Birth weight ___ Was the baby born at term? ____ OR ____ Weeks
Were there any prenatal or neonatal complications?
□ Yes □ No Explain _____
_____
Was a NICU stay required? □ Yes □ No Explain_____
_____
During pregnancy, did mother
Use tobacco □ Yes □ No Drink alcohol □ Yes □ No
Use drugs or medication □ Yes □ No
Use prenatal vitamin □ Yes □ No
What _____ When _____

Was the delivery □ Vaginal □ Cesarean
If cesarean, why? _____
_____
_____

Did baby go home with mother from the hospital?
□ Yes □ No Explain _____
_____
_____

General DK= Don't know

Do you consider your child to be in good health? □ Yes □ No □ DK Explain _____
Does your child have any serious illness or medical conditions? □ Yes □ No □ DK Explain _____
Has your child had any surgery? □ Yes □ No □ DK Explain_____
Has your child ever been hospitalized? □ Yes □ No □ DK Explain _____
Is your child taking any medication? □ Yes □ No □ DK Explain _____
Is your child allergic to medicine or drugs? □ Yes □ No □ DK Explain _____
Do you feel your family has enough to eat? □ Yes □ No □ DK Explain _____
Are there any religious/ cultural consideration regarding your care? □ Yes □ No
If yes, please explain _____
Preferred Language _____

Continued on back

School/Social

Does your child attend school/preschool/daycare? □ Yes □ No

Name of school _____ Grade_____

Concerns about school performance? □ Yes □ No

If yes, please explain_____

Concerns about peer or teacher relationships? □ Yes □ No

If yes, please explain_____

Safety

Concerns about your child □ Drug/Alcohol use □ Tobacco □ Sexual activity □ Aggressive behavior

Is violence at home a concern □ Yes □ No

Sports/exercise: Type_____ How often_____ How long (minutes)_____ □N/A

Seatbelt use □Always □Sometimes □Never

Helmet use □ Always □Sometimes □Never

Past History DK= Don't know

Does your child have, or has your child ever had:

ADHD/anxiety/mood problems/depression	□ Yes	□ No	□ DK	Explain_____
Alcohol or Drug Abuse	□ Yes	□ No	□ DK	Explain_____
Anemia or bleeding problem	□ Yes	□ No	□ DK	Explain_____
Asthma, bronchiolitis, or pneumonia	□ Yes	□ No	□ DK	Explain_____
Bed-wetting (after age 5)	□ Yes	□ No	□ DK	Explain_____
Cancer	□ Yes	□ No	□ DK	Explain_____
Chicken Pox	□ Yes	□ No	□ DK	Explain_____
Chronic Allergic Rhinitis	□ Yes	□ No	□ DK	Explain_____
Chronic or recurrent skin problems (e.g. acne, eczema)	□ Yes	□ No	□ DK	Explain_____
Congenital cataracts/retinoblastoma	□ Yes	□ No	□ DK	Explain_____
Constipation requiring doctor visit	□ Yes	□ No	□ DK	Explain_____
Convulsions or neurologic problems	□ Yes	□ No	□ DK	Explain_____
Dental decay	□ Yes	□ No	□ DK	Explain_____
Developmental delay	□ Yes	□ No	□ DK	Explain_____
Diabetes	□ Yes	□ No	□ DK	Explain_____
Frequent abdominal pain	□ Yes	□ No	□ DK	Explain_____
Frequent ear infections	□ Yes	□ No	□ DK	Explain_____
Frequent headaches	□ Yes	□ No	□ DK	Explain_____
Heart problem or heart murmur	□ Yes	□ No	□ DK	Explain_____
High blood pressure	□ Yes	□ No	□ DK	Explain_____
History or serious injuries/fractures/concussions	□ Yes	□ No	□ DK	Explain_____
HIV	□ Yes	□ No	□ DK	Explain_____
Kidney disease or urologic malformations	□ Yes	□ No	□ DK	Explain_____
Metabolic/Genetic disorders	□ Yes	□ No	□ DK	Explain_____

Continued on back

Obesity	□ Yes	□ No	□ DK	Explain_____
Organ transplant	□ Yes	□ No	□ DK	Explain_____
Other Mental Illness	□ Yes	□ No	□ DK	Explain_____
Sleep problems/ snoring	□ Yes	□ No	□ DK	Explain_____
Thyroid or other endocrine problems	□ Yes	□ No	□ DK	Explain_____
(For girls) Problems with periods	□ Yes	□ No	□ DK	Explain_____
Has had first period	□ Yes	□ No	□ DK	Age of first period_____
Any other significant problem	□ Yes	□ No	□ DK	Explain_____

_____ _____

Biological Family History DK= Don't know

Have any family members had the following?

Alcohol or drug abuse	□ Yes	□ No	□ DK	Who_____	Comments_____
Anemia	□ Yes	□ No	□ DK	Who_____	Comments_____
Asthma	□ Yes	□ No	□ DK	Who_____	Comments_____
Bleeding disorder	□ Yes	□ No	□ DK	Who_____	Comments_____
Cancer (before age 55)	□ Yes	□ No	□ DK	Who_____	Comments_____
Childhood hearing loss	□ Yes	□ No	□ DK	Who_____	Comments_____
Chronic Allergic Rhinitis	□ Yes	□ No	□ DK	Who_____	Comments_____
Developmental disability	□ Yes	□ No	□ DK	Who_____	Comments_____
Diabetes	□ Yes	□ No	□ DK	Who_____	Comments_____
Epilepsy or convulsions	□ Yes	□ No	□ DK	Who_____	Comments_____
Heart disease (before age 55)	□ Yes	□ No	□ DK	Who_____	Comments_____
High cholesterol/ takes cholesterol medication	□ Yes	□ No	□ DK	Who_____	Comments_____
Immune problems, HIV, AIDS	□ Yes	□ No	□ DK	Who_____	Comments_____
Kidney disease	□ Yes	□ No	□ DK	Who_____	Comments_____
Liver disease	□ Yes	□ No	□ DK	Who_____	Comments_____
Mental illness/ Depression	□ Yes	□ No	□ DK	Who_____	Comments_____
Obesity	□ Yes	□ No	□ DK	Who_____	Comments_____
Tobacco use	□ Yes	□ No	□ DK	Who_____	Comments_____

Additional family history _____