***This 5-page form takes about 20 minutes to complete. If you are unsure of any areas, it is fine to leave them blank and you may discuss it with your physician.**

Today's Date: _____

Child's Name: _____ Date of birth: _____

What would your child like to be called (nickname): _____

WHO IS YOUR CHILD'S PRIMARY PHYSICIAN: _____

Date your child was last seen by their previous primary doctor? _____ Location: _____

FOR CHILDREN AGES 1 MONTH TO 12 YEARS:

PREGNANCY/BIRTH/NEWBORN HISTORY: If you are not certain of the answers to the following questions, please leave blank

For Children 0-2 Years Only: What were your child's APGAR scores: 1 minute _____ 5 minutes_____ 10 minutes_____

For Children ages 1 month to 12 years:

What was your child's: birth weight ____ birth length _____ head circumference _____ hospital discharge weight _____

What was your child's gestational age (what week, 1-40, did you give birth): _____

What was the delivery method for your child (eg. Vaginal, C-section):_____ How long was labor_____

How many days was your child in the hospital following birth? _____ Hospital name:_____ City/state:_____

Did your child have any complications at birth? _____

Were there any maternal complications associated with pregnancy or delivery?_____

DO YOU HAVE ANY CONCERNS/QUESTIONS THAT YOU WOULD LIKE TO ADDRESS AT YOUR CHILD'S FIRST VISIT?

(Explain concerns):

ALLERGIES: (Food and/or Medication) List specific allergen and specific reaction (e.g. Amoxicillin causes hives and itching):

☐ NONE:

Have you or your child experienced any serious reactions to an immunization? NO/YES

If so, which one(s)? _____

MEDICATIONS: Include prescription and over-the-counter taken on a CONSISTENT basis:

Medication: (e.g. Ranitidine 75 mg twice daily):	Dose:	Directions/Times Per Day:	☐ NONE:
1)			
2)			
3)			
4)			

PAST SURGICAL HISTORY (List surgery, date, hospital/surgeon - e.g. Ear tubes; July 1, 2011; Dr. Heargood):

1) _____
2) _____
3) _____
4) _____

HOSPITALIZATIONS/SERIOUS INJURIES (List problem, date and hospital/location):

1) _____
2) _____
3) _____
4) _____

SPECIFIC HEALTH ISSUES:

Please check whether you or your child have **questions** or are **worried** about any of the following:

_____Height/Weight
_____Blood Pressure
_____Diet/food/appetite
_____Skin (rash, acne)
_____Headaches/migraines
_____Dizziness/fainting
_____Eyes/vision
_____Ears/hearing/earaches
_____Frequent colds/sinus infections
_____Mouth/teeth/breath
_____Neck/back
_____Chest pain/trouble breathing
_____Coughing/wheezing
_____Heart
_____Stomach ache
_____Nausea/vomiting
_____Diarrhea/constipation
_____Puberty/Body Changes
_____Muscle or joint pain (arms/legs)
_____Frequent or painful urination
_____Trouble sleeping
_____Feeling tired
_____Other (explain) _____

EMOTIONAL/SOCIAL ISSUES:

Please check whether you or your child have **questions** or are **worried** about any of the following:

_____Anxiety
_____Depression
_____Stress
_____Fear of dying (self or others)
_____Drugs or alcohol
_____Smoking
_____Peer pressures
_____Social interactions
_____Body image
_____Anger
_____Developmental/school/academic problems
_____Other (explain)_____

ENVIRONMENTAL/HOME:

Is your child adopted? YES / NO

With whom does your child live? (Check all that apply)

_____Mother
_____Father
_____Guardian/Foster parent
_____2 Mothers
_____2 Fathers
_____Stepmother
_____Stepfather
_____Other adult relative
_____Brother(s)/ages _____
_____Sister(s) _____
_____Other (explain) _____

During the past year, have there been any changes in your family such as: (check all that apply)

_____Marriage
_____Separation
_____Divorce
_____Births
_____Deaths
_____Serious Illness/Injury
_____Moved to a new neighborhood
_____A new school
_____Loss of job
_____Other _____
_____Exposure to domestic violence (yelling, hitting, pushing, etc)

SCHOOL:

Is your child home schooled? YES / NO

Where does your child go to school? _____ What grade? _____

Are you satisfied with your child's school performance? YES / NO (If yes, explain concerns:)

Does your child have any learning difficulties? YES / NO (If yes, explain concerns:)

HEALTH PROFILE:

How many servings of fruits and vegetables does your child eat in an average day? _____

How many servings of dairy (milk, cheese, yogurt) does your child eat per day? _____

Does your child brush his/her teeth every day? YES / NO

Has your child been to see a dentist in the last year? (circle) YES / NO

What does your child do for exercise? _____

Does your child exercise (run, swim, bike, dance, play basketball, etc.) for at least 60 minutes 5 or more days a week? YES / NO

On an average school night, how many hours of sleep does your child get? _____

Screen time: in an average day, how much time does your child spend
watching TV, playing video games, social networking on computer or any other screen time? _____

Does your child always wear a lap/seat belt when riding in a car, truck, or van? YES / NO

Does your child always wear a helmet when biking, rollerblading, skateboarding, skiing, snowboarding,
riding a motorcycle or ATV? YES / NO

Are you adopted? _____ YES _____ NO

If no, please check the box associated with family members who currently have or have had the following medical conditions:

If yes, but you know history of any blood relatives, please check the appropriate boxes below.

Be sure to complete front and back of this form.

Relationship:	**Name:**	**STATUS: (alive/ deceased)**	Hypertension	Coronary/Heart	Aneurysm	Stroke/CVA	Cholesterol Disorder	Diabetes Mellitus	Thyroid Disease	Allergies/Asthma	Immunologic Disorder	Autoimmune Disease	Cancer Breast	Cancer Ovarian	Cancer Uterine	Cancer Colon	Cancer Prostate	Cancer Other	Gastrointestinal Disease	Kidney Disease
Father		A / D																		
Mother		A / D																		
Son(s):		A / D																		
		A / D																		
		A / D																		
Daughter(s):		A / D																		
		A / D																		
		A / D																		
Sister(s):		A / D																		
		A / D																		
		A / D																		
Brother(s):		A / D																		
		A / D																		
		A / D																		
Mom's Mother (MGrandmother)		A / D																		
Dad's Mother (PGrandmother)		A / D																		
Mom's Father (MGrandfather)		A / D																		
Dad's Father (PGrandfather)		A / D																		
Mom's Sisters (MAunt)		A / D																		
Dad's Sisters (PAunt)		A / D																		
Mom's Brothers (MUncle)		A / D																		
Dad's Brothers (PUncle)		A / D																		
Other		A / D																		

Relationship:	Name:	Strabismus / Lazy Eye	Deafness	Anemia	Bleeding Disorder	Sickle Cell Disease	Neurological Disorder	ADD/ADHD	Learning Disablity	Depression	Anxiety	Psych Other	Dementia	Alcohol/Drug	Osteoporosis	Other	Unknown FHx
Father																	
Mother																	
Son(s):																	
Daughter(s):																	
Sister(s):																	
Brother(s):																	
Mom's Mother (MGrandmother)																	
Dad's Mother (PGrandmother)																	
Mom's Father (MGrandfather)																	
Dad's Father (PGrandfather)																	
Mom's Sisters (MAunt)																	
Dad's Sisters (PAunt)																	
Mom's Brothers (MUncle)																	
Dad's Brothers (PUncle)																	
Other																	