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Child's Name: _____

Today's Date: _____

Person completing form _____

Relation to child: _____

Purpose of FIRST VISIT: Well Visit School/Sports Exam Particular Problem: _____

NEW PATIENT HISTORY - Your child's medical history is important. Please provide the following information before your first visit; all information is kept confidentially along your child's medical records.

BIRTH HISTORY:

Where was your child born? _____ Birth Weight _____
 Was child's mother ill or take any medications during pregnancy? No YES
 Was the delivery NOT on time (was baby born too early or late?) No YES
 Did your child have any trouble starting to breathe? No YES
 Did your baby have problems in the hospital nursery (breathing, jaundice, infection, etc)? ... No YES
 Did your infant remain in the hospital after mother was discharged? No YES

ALLERGIES / MEDICATIONS:

Is your child ALLERGIC to any medicines or foods?..... No YES – List Below

Are there any MEDICATIONS which your child takes regularly?..... No YES – List Below

Circle if your child takes: vitamins iron containing vitamins fluoride other nutritional supplements

ILLNESSES – Please list with dates:

Hospitalizations Operations Serious Illness Serious Injuries / Fractures

Does your child have any problem with HEARING or VISION?..... No YES

Any history of CONCUSSION or loss of consciousness?..... No YES

In the last 12 months, how many EAR INFECTIONS has your child had? _____ TONSILLITIS? _____

Please CIRCLE any illnesses below which your child has experienced:

- | | | |
|----------------------------|--------------------------------|--------------------------|
| Atopic Dermatitis / Eczema | Strep Throat / Scarlet Fever | Sinus Problems |
| Hives / Urticaria | Chicken Pox (Varicella) | Other special illnesses: |
| Wheezing / Asthma | Urine/Kidney/bladder infection | |
| Pneumonia / Bronchitis | Seizure / Convulsion | |

DIET / ELIMINATION:

Do you have concerns about your child's APPETITE or DIET?..... No YES

Do you RESTRICT or AVOID items from your child's diet for any reason?..... No YES

Has your child had recurring or severe DIARRHEA?..... No YES

Has your child had problems with HARD or PAINFUL stools?..... No YES

DEVELOPMENT / BEHAVIOR:

When did your child: sit alone? _____ walk without assistance? _____ say words? _____
Does your child have any *difficulty sleeping*? No YES
Does your child *get along well* in school with other children? Adults? Teachers?? YES No
Does your child have any delays in language or other developmental skills ? No YES
Do you have any other behavioral problems which concern you? No YES
Do you have concerns regarding toilet training difficulties or bedwetting? No YES

FAMILY HISTORY - CIRCLE if parent, grandparent, siblings or other relatives have had:

Heart problems occurring UNDER age 55 (heart attack, angina, stroke)
High blood pressure Diabetes
Asthma, hay fever Cancer (type?)
Anemia, bleeding problems Tuberculosis
Immunodeficiency, Hepatitis, or HIV positive individuals
Epilepsy, seizures Kidney disease
Developmental delay / mental retardation Thyroid disease
Congenital anomalies/defects (such as deformed ear, digits....) Other inherited/family diseases (list):

(Biologic) Mother's age _____ Height: _____ Weight: _____ **Good Health?**.... No YES
(Biologic) Father's age _____ Height: _____ Weight: _____ **Good Health?**.... No YES
Did this child's mother have any miscarriages or stillbirths? No YES
Please list name, age and general health of **brothers and sisters**
_____ AGE: _____ In Good Health?: YES No
_____ AGE: _____ In Good Health?: No YES
_____ AGE: _____ In Good Health?: No YES
_____ AGE: _____ In Good Health?: No YES
Have any of your children died? No YES

CARE ROUTINES: (circle all that apply):

Where does your youngster *usually spend* most of the day during weekdays:
Child Care Preschool School: 1 2 3 4 5 days a week; _____ hours a day
HOME with: mother father grandparent sitter aunt/uncle **other (list):** _____
Biologic parents are currently: [] married [] separated [] divorced [] deceased
How many hours per week do parents typically work outside of the home? Mother: _____ Father: _____

IMMUNIZATIONS

Please arrange to bring or have transferred all immunization cards and documents to verify vaccination dates:

Do you believe that all your child's shots are *up to date* at this time? YES No
Has your child experienced any serious or unusual *reactions* to any vaccination? No YES
Has your child had a **tuberculin (TB) skin test** within the last year? Unsure No YES
If so, was it negative (normal)? YES No

HEALTH CARE PROVIDERS:

Does your child see a dentist regularly? YES No
Who was the most recent pediatrician or general physician to care for your child:

List specialists (eye doctor, therapists, etc) & consultants actively involved in your child's health care:

Please list parent's doctors: _____