

**CHILD'S NAME** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
Last Name First Middle

**Mother's Name** \_\_\_\_\_ **Profession** \_\_\_\_\_  
Last Name First

**Father's Name** \_\_\_\_\_ **Profession** \_\_\_\_\_  
Last Name First

List all siblings living in the home: \_\_\_\_\_

**PRE-NATAL AND BIRTH HISTORY OF CHILD**

Pregnancy: Any illnesses or complications? Y N \_\_\_\_\_  
Any smoking, alcohol, or recreational drug use during pregnancy? Y N \_\_\_\_\_

Delivery: Any complications? Y N \_\_\_\_\_  
Baby's Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Head \_\_\_\_\_ Hospital \_\_\_\_\_  
Problems at or after birth? \_\_\_\_\_  
Did your baby need any blood transfusions after birth? Y N \_\_\_\_\_

**CHILD'S ALLERGIES TO**

**Medications** (Date and symptoms): \_\_\_\_\_

**Foods:** \_\_\_\_\_

**PAST MEDICAL HISTORY OF CHILD**

Hospitalizations or outpatient surgeries (when, where and why): \_\_\_\_\_

Serious injuries (when, where): \_\_\_\_\_

Previous MD / Clinic \_\_\_\_\_ Dentist \_\_\_\_\_  
Fluoride: medication / water / none

**Your child's previous or current conditions: (Circle all relevant)**

Recurrent ear infection (>3)	Constipation	Seizures	Mental / Emotional Prob.
Recurrent throat infect. (>3)	Chickenpox	Eye problems	Cigarette smoker
Allergies / Sinus problems	Scarlet fever	Hearing problems	Drug / Alcohol use
Asthma / Wheezing	Stomachaches	Kidney / Bladder infections	Tattoos / Body Piercing
Eczema	Headaches	Blood transfusions	

Other: \_\_\_\_\_

**FAMILY HISTORY OF CHILD**

List child's blood relatives with these problems: (M) Mother, (F) Father, (S) Sister, (B) Brother, (MGM) Mother's mother, (MGF) Mother's father, (PGM) Father's mother, (PGF) Father's father, (A) Aunt, (U) Uncle, (C) Cousin

AIDS _____	Drug problem _____	Muscular disease _____
Allergies _____	Eye problems _____	Neurological disease _____
Alcohol problem _____	G.I. disease _____	Seizure _____
Anemia _____	Hearing problems _____	Skin problems _____
Asthma _____	Heart attack (age?) _____	Sudden death _____
Arthritis _____	Heart disease _____	Thyroid disease _____
Birth defects _____	High blood pressure _____	Tobacco use _____
Blindness _____	High cholesterol _____	Tuberculosis _____
Cancer _____	Kidney disease _____	Peptic ulcer _____
Cholesterol >240 _____	Learning problems _____	Other _____
Cystic fibrosis _____	Mental illness _____	
Deafness _____	Mental retardation _____	
Diabetes _____	Migraine _____	

**Are there pets in the home?**

**Are there guns in the home?**

**Is there anything else we need to know about?**

Signature of person completing this form \_\_\_\_\_