[LOGO HERE]

Initial Patient History

Patient Name: [_____] Date of Birth: [_____]

Birth History

Birth Weight: [_____]lbs. [____]oz. Length at Birth: [_____]in. []Term []Preterm [_____] weeks
[]Vaginal Delivery []C-Section (If C-Section, list reason: [_____])
Was child exposed prenatally to: []Smoke []Drugs []Alcohol? []None

Pregnancy or Delivery Complications if any:[_____]
Problems with baby after birth, if any: [_____] Length of hospital stay [_____]days

[]Patient Birth History Unkown Reason Unknown []Adoption []Foster care []Other [_____]

Social History

With Whom Does Patient Live: [_____]

What type of home: []Apartment []Single Family House []Mobile Home

Parents' Marital Status: []Married []Divorced []Single

Are there any smokers in the home? []No []Yes If yes, Whom? [_____]
Are there any pets in the home? []No []Yes How many [_____]

What type of pet? []Dog []Cat []Fish []Reptile []Bird []Other [_____]

Medications

Current Medications: []Yes []No (If yes, please list below)

Medication: [_____] Dosage: [_____] Frequency: [_____]

Medication: [_____] Dosage: [_____] Frequency: [_____]

Medication: [_____] Dosage: [_____] Frequency: [_____]

Medication: [_____] Dosage: [_____] Frequency: [_____]

Medication: [_____] Dosage: [_____] Frequency: [_____]

Drug Allergies? []No []Yes Medication & Reaction: _____

Surgeries

[] No Surgeries

Circumcision: []Yes []No Date:[_____]

Ear Tubes: []Yes []No []Multiple Most Recent Date:[_____]

Tonsils/Adenoids: []Yes []No Date:[_____]

Other: [_____] Date:[_____]

Hospitalizations

[]No Hospitalizations

Reason:[_____] Age / Dates:[_____]

Reason:[_____] Age / Dates:[_____]

Reason:[_____] Age / Dates:[_____]

Reason:[_____] Age / Dates:[_____]

Past Medical History

Does the patient currently have or has the patient ever had any of the following:

[]No current or past health concerns

[]Unexplained Weight Change	[]Vision Problems	[]Hearing difficulty
[]Snoring/Mouth Breathing	[]Headaches	[]Seizures
[]Chronic Sore Throat	[]Heart Problems	[]Asthma
[]GERD/Reflux	[]Constipation	[]Allergies or Chronic Runny Nose
[]Unexplained Joint Pain	[]Abnormal Walking	[]Bedwetting after age 7
[]Persistent Rash	[]Unusual Moles	[]Fainting
[]ADD / ADHD	[]Anxiety / Depression	[]Diabetes
[]Easy Bruising/Bleeding	[]Thyroid Problems	[]High Cholesterol

[]Other [_____]

Family Medical History

(Please make the following selectable options of family member to be within a multiple selection dropbox [Family Multiple Selection Dropbox] or [FMSDB]. Thank you.)

[]Sister []Brother []Mother []Father []Maternal Aunt []Maternal Uncle []Maternal Cousin []Maternal Grandmother []Maternal Grandfather []Paternal Aunt []Paternal Uncle []Paternal Cousin []Paternal Grandmother []Paternal Grandfather

ADD / ADHD: [FMSDB]

Anemia / Bleeding Disorder: [FMSDB]

Asthma / Lung Disoder: [FMSDB]

Autism: [FMSDB]

Birth Defect: [FMSDB]

Cancer: [FMSDB]

Deafness / Hearing Loss: [FMSDB]

Diabetes: [FMSDB]

Eczema / Skin Disease: [FMSDB]

Genetic Disease: [FMSDB]

Heart Disease / Stroke: [FMSDB]

High Blood Pressure: [FMSDB]

High Cholesterol: [FMSDB]

Immune Disorder: [FMSDB]

Intestinal or Liver Disease: [FMSDB]

Learning Problems: [FMSDB]

Metabolic / Muscle Disorder: [FMSDB]

Neurologic Disorder / Seizure: [FMSDB]

Psychiatric Disorder: [FMSDB]

Urinary Tract / Kidney Disease: [FMSDB]

Thyroid Disease: [FMSDB]

[] None

Other: [_____]

Medical History Unknown: []Maternal Family History []Paternal Family History