

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Pt# \_\_\_\_\_

### Birth History

How many pregnancies has mom had: \_\_\_\_\_ How many children has mom had: \_\_\_\_\_  
Was the child full term: \_\_\_\_\_ Birth Weight \_\_\_\_\_ Length \_\_\_\_\_  
If early, how many weeks? \_\_\_\_\_ Hospital \_\_\_\_\_ C-section Vaginal Delivery  
Complications during pregnancy: \_\_\_\_\_  
Did the child go to the regular nursery or NICU \_\_\_\_\_ were they on the vent? \_\_\_\_\_  
When did they go home from the hospital? \_\_\_\_\_  
Did they have any problems? jaundice phototherapy colic poor weight gain anemia breast- fed  
formula- fed (type) \_\_\_\_\_ other \_\_\_\_\_

### Past Medical History

Hospitalizations \_\_\_\_\_ ER visits \_\_\_\_\_  
Broken bones \_\_\_\_\_ Surgeries \_\_\_\_\_  
Recurrent ear infections \_\_\_\_\_ Tubes? \_\_\_\_\_ ENT \_\_\_\_\_  
Recurrent strep \_\_\_\_\_ tonsils out? \_\_\_\_\_ when \_\_\_\_\_  
Asthma or albuterol use \_\_\_\_\_ Meds \_\_\_\_\_  
Allergies NONE environmental medication reaction to \_\_\_\_\_  
Chronic illnesses \_\_\_\_\_ Urinary tract infections \_\_\_\_\_  
Behavior problems \_\_\_\_\_ ADHD \_\_\_\_\_ Sleep problems \_\_\_\_\_  
Hurting animals \_\_\_\_\_ Fire starter \_\_\_\_\_ Legal problems \_\_\_\_\_  
Physical or sexual abuse \_\_\_\_\_ counseling \_\_\_\_\_ with? \_\_\_\_\_  
Depression/Anxiety \_\_\_\_\_ up to date on shots \_\_\_\_\_  
Have they started their periods? \_\_\_\_\_ last one date \_\_\_\_\_  
Any concerns about physical development or puberty? \_\_\_\_\_  
Problems with: bed wetting nightmares rashes discharge headaches violent behaviorseizures constipation diarrhea  
Have they had Chicken Pox? \_\_\_\_\_ Has your child seen a Dentist? \_\_\_\_\_ Who? \_\_\_\_\_ Last visit \_\_\_\_\_

### Social History

Lives with \_\_\_\_\_ Are parents together? \_\_\_\_\_ Siblings \_\_\_\_\_  
Who is involved in parenting/care taking? \_\_\_\_\_  
Is there regular visitation to another household? Whose? \_\_\_\_\_  
Are there smokers? \_\_\_\_\_ city water well water Has well water been tested? \_\_\_\_\_  
How does the child eat? \_\_\_\_\_ are they picky? \_\_\_\_\_ Any concerns? \_\_\_\_\_  
Does the child take vitamins? \_\_\_\_\_ other supplements \_\_\_\_\_  
Have they had a lead level or CBC recently? \_\_\_\_\_ Where? \_\_\_\_\_

### Family History —parents, siblings and grandparents have/had:

|             |                     |                   |                   |       |
|-------------|---------------------|-------------------|-------------------|-------|
| Adopted     | Asthma              | Heart Disease     | Cancer            | _____ |
| Diabetes    | High Blood Pressure | High Cholesterol  | Obesity           | _____ |
| Depression  | Anxiety             | Suicide           | Kidney Disease    | _____ |
| Thyroid     | Hearing deficit     | Domestic problems | Learning problems | _____ |
| Sickle cell | Genetic problems    | Unexplained death | other             | _____ |

### School History

Grade \_\_\_\_\_ Age \_\_\_\_\_ Academic performance \_\_\_\_\_  
Difficulties \_\_\_\_\_ Resource classes \_\_\_\_\_  
Failed or repeated grade \_\_\_\_\_ Behavior \_\_\_\_\_  
Extra-curricular activities \_\_\_\_\_  
Additional concerns: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_