



Date: _____

Initial Patient History

Patient name: _____ Patient D.O.B. _____

Male _____ Female _____

Parents/Guardians name: _____

With whom does the patient live? _____

Name of Sibling **Age**

Name of Sibling	Age

Birth History

Pregnancy complications, if any: _____

Did mother smoke, use drugs, or alcohol? Yes No

Birth Weight _____ Length at Birth _____ Term Preterm _____

Vaginal delivery C-section Delivery Complications, if any: _____

Problems with baby after birth, if any: _____

Family History

Allergies/Asthma		Ear infections/tubes	
Eczema		Seizure disorder	
High Cholesterol		Learning/attention problems	
High Blood Pressure		Depression/Anxiety	
Heart disease/ Stroke		Drug/Alcohol abuse	
Cancer		Mental Retardation	
Anemia/ Bleeding disorder		Hearing loss/ deafness	
Diabetes		Vision loss	
Thyroid problems		Kidney disorder	
Gastrointestinal disorder		HIV/Hepatitis/ Tuberculosis	

(See Reverse Side)



Past Medical History

Drug allergies? No Yes (medication & reaction) _____

Surgery/Reason for Hospitalization	Date

Has your child ever had chickenpox? Approximate date: _____

Current medication	Dosage	Prescribed By

Review of Systems

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

Allergies, Asthma or Respiratory Problems	
Eye, Ear, Nose or Throat Problems	
Heart Murmur or Heart Problems	
Anemia or Bleeding problems	
Abdominal Pain, Constipation, Vomiting or Diarrhea	
Bladder or Kidney Problems	
Skin Rashes or Problems (acne, eczema, etc.)	
Headaches, Seizures, ADHD	
Diabetes or Thyroid Problems	
Fever, Decreased Activity, Poor Appetite	
Behavior or Attention Problems	
Other Problems	