

General InformationPatient's full name: Patient's date of birth: Nickname: Patient's previous doctor: (Optional) Race: Ethnicity: ☐ Hispanic ☐ Non Hispanic**Current medications**

Please include vitamins, supplements and herbs:

Allergies☐ None☐ Food: ☐ Seasonal: ☐ Other: **Pregnancy and Delivery**Where was patient born? (State and hospital):

Is the patient yours by:

☐ Birth☐ Adoption☐ Stepchild☐ Foster child☐ Other:

Pregnancy:

Any medications taken during pregnancy:

☐ None☐ Prenatal vitamins☐ Other:

Please indicate any complications during pregnancy:

☐

Delivery:

☐ Vaginal ☐ Caesarian Section ☐ BreechBirth weight: Birth length: ☐ Premature & how early?

Please indicate any delivery complications including

NICU if relevant: **Immunizations** **Please bring a copy of your immunization record to your first appointment, or send it by mail or fax with this form.**☐ Immunizations current☐ Behind on immunizations & why: ☐ Not immunized & why: **Family Social History**

Who lives at home with patient? (Include parents, siblings, grandparents, etc.)

Household #1

Name	Age	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Household #2

Name	Age	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If patient spends time in two households, describe

custody arrangements (50/50, etc): Parent #1 occupation: Parent #1 employer: Parent #2 occupation: Parent #2 employer:

Past Medical History

☐ Current or previous medical diagnoses: _____

☐ Hospitalizations & why? (Include age or date): _____

☐ Surgeries & why? (Include age or date): _____

☐ Injuries, concussions, fractures, stitches, etc: _____

Development:

Have you or a previous provider had concerns regarding your child's development (speech, gross motor, fine motor, etc)? ☐ Yes ☐ No

If Yes, please describe: _____

Have you or a previous provider had concerns regarding your child's puberty timing (early or late)?

☐ Yes ☐ No

If Yes, please describe: _____

Has your child started menstruating (period)?

☐ Yes ☐ No ☐ N/A

Nutrition:

☐ Eats a well-balanced diet ☐ Vegetarian

☐ Vegan ☐ Picky eating or nutritional concerns

Has your child had any dietary or feeding problems? ☐ Yes ☐ No

If yes, please explain: _____

Sleep:

Hours per night: _____

Any sleep problems? _____

Dental:

Is the patient seeing a dentist? ☐ Yes ☐ No

Dental problems or concerns: _____

School:

Current school: _____

Grade level: _____

Any concerns about school performance?

☐ Yes ☐ No If yes, please explain: _____

Mental Health:

Have you or a previous provider had concerns regarding your child's behavior/emotional needs?

☐ Yes ☐ No

If Yes, please describe: _____

If Yes, has your child had any evaluations or therapy? _____

Activities/Exposures/Habits:

☐ Physical Activity: _____

☐ Other activities: _____

Number of hours per day of screen time (TV, computers, video games, etc.): _____

Any family members smoke (inside or outside)?

☐ Yes ☐ No

Firearms in the home? ☐ Yes ☐ No

If yes, are locked? ☐ Yes ☐ No

Review of All Systems: Please check any current or past medical problems your child has had.

General:

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Unexplained weight gain |

Eyes:

- | | |
|--|---|
| <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Wears contacts |
| <input type="checkbox"/> Lazy eye(s) | <input type="checkbox"/> Crossed eyes |

Ears, Nose & Throat:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent runny nose |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Frequent bloody nose |
| <input type="checkbox"/> Frequent sore throats or strep throat | |
| <input type="checkbox"/> Problems with teeth and gums | |

Respiratory:

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> RAD or wheezing | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Recurrent croup | <input type="checkbox"/> EIB |
| <input type="checkbox"/> Shortness of breath with exercise | |

Cardiovascular:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart defect |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Poor endurance compared to peers | |

Gastrointestinal:

- | | |
|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Unexplained vomiting |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Frequent stomachaches |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Soiling underwear |

Genitourinary:

- | | |
|---|--|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Daytime wetting |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Urinary reflux | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> PMS |

Musculoskeletal:

- | | |
|--|---|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Head injuries |
| <input type="checkbox"/> Concussions - If so, indicate the # _____ | |

Neurological:

- | | |
|---|---|
| <input type="checkbox"/> Tension headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Staring spells |

Psychiatric, Emotional & Education:

- | | |
|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> Anxiety/Stress | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Aggression/Fighting | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Sleep difficulty | <input type="checkbox"/> IEP |
| <input type="checkbox"/> Learning difficulty | <input type="checkbox"/> Substance abuse |

Skin:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Unusual moles | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Bruising |

Endocrine:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Short stature | <input type="checkbox"/> Precocious puberty |

Specific infections (Plus age or date of infection):

- | | |
|---|---|
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> RSV _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Whooping cough (Pertussis) _____ | |

Any other concerns? _____

Family History: Please indicate using the following key any family members who at any time in their lives have been diagnosed with any of these conditions. Please indicate if any family members have died from any of these conditions.

KEY-PLEASE USE THE FOLLOWING IDENTIFIERS FOR FILLING OUT THE FAMILY HISTORY

Mother = Mother of Patient	Brother = Brother of Patient	Grandfather = Patient's Grandfather	Aunt = Mother or Father's Sister	Cousin = Cousin of Patient
Father = Father of Patient	Sister = Sister of Patient	Grandmother = Patient's Grandmother	Uncle = Mother or Father's Brother	

Mother's Family History

ADHD _____
 Alcoholism/Substance abuse _____
 Allergies _____
 Alzheimer's _____
 Anemia _____
 Anxiety _____
 Asthma _____
 Childhood asthma _____
 Arthritis _____
 Autism _____
 Autoimmune diseases _____
 Bipolar disorder _____
 Birth defect _____
 Bladder problems _____
 Bleeding disorders _____
 Blood diseases _____
 Cancer (Type) _____
 Celiac _____
 COPD _____
 Developmental disabilities _____
 Depression _____
 Suicide _____
 Diabetes _____
 Eating disorder _____
 Educational difficulties _____
 GI disorders (Reflux, Colitis, Crohn's) _____
 Hearing loss _____
 Heart disease _____
 Heart arrhythmia (Prolonged QT, SVT) _____
 High blood pressure _____
 High cholesterol _____
 Hip dysplasia _____
 Kidney disease _____
 Lazy eye (Strabismus) _____
 Melanoma _____
 Mental illness _____
 Migraine headaches _____
 Obesity/Overweight _____
 Renal reflux _____
 Rheumatological disease _____
 Scoliosis _____
 Seizures _____
 Epilepsy _____
 Stroke _____
 Sudden cardiac death _____
 Sudden unexplained death _____
 Thrombosis (Blood clot) _____
 Thyroid disease _____
 Other _____

Father's Family History

ADHD _____
 Alcoholism/Substance abuse _____
 Allergies _____
 Alzheimer's _____
 Anemia _____
 Anxiety _____
 Asthma _____
 Childhood asthma _____
 Arthritis _____
 Autism _____
 Autoimmune diseases _____
 Bipolar disorder _____
 Birth defect _____
 Bladder problems _____
 Bleeding disorders _____
 Blood diseases _____
 Cancer (Type) _____
 Celiac _____
 COPD _____
 Developmental disabilities _____
 Depression _____
 Suicide _____
 Diabetes _____
 Eating disorder _____
 Educational difficulties _____
 GI disorders (Reflux, Colitis, Crohn's) _____
 Hearing loss _____
 Heart disease _____
 Heart arrhythmia (Prolonged QT, SVT) _____
 High blood pressure _____
 High cholesterol _____
 Hip dysplasia _____
 Kidney disease _____
 Lazy eye (Strabismus) _____
 Melanoma _____
 Mental illness _____
 Migraine headaches _____
 Obesity/Overweight _____
 Renal reflux _____
 Rheumatological disease _____
 Scoliosis _____
 Seizures _____
 Epilepsy _____
 Stroke _____
 Sudden cardiac death _____
 Sudden unexplained death _____
 Thrombosis (Blood clot) _____
 Thyroid disease _____
 Other _____