

PATIENT HISTORY/HISTORIA DEL PACIENTE

Patient's Name: _____ Date of Birth: ____/____/____ Age: _____

Your Name: _____ Relationship to child: _____

Child's Past Medical History/ Historial Medico del paciente

Pregnancy/Neonatal Period

Where was your child born? _____ Is the child yours by birth adoption stepchild other _____

Pregnancy Complications Yes No. If yes, explain _____

Delivered by Vaginal C-Section If C-Section, explain reason _____ Complications _____

Was your child premature? No Yes, Born at _____ weeks. Complications _____

Apgar Scores: 1 minute _____ 5 minutes _____ Birth Weight: _____ lbs _____ oz Birth Length _____

Other problems in the newborn period _____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (*explain*)

| | | | |
|--|--|--|--|
| <input type="checkbox"/> Asthma or Reactive Airway Disease | | <input type="checkbox"/> Generic Syndrome | |
| <input type="checkbox"/> Wheezing or Bronchiolitis | | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Seasonal Allergies or Eczema | | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Food Allergy | | <input type="checkbox"/> Broken Bone | |
| <input type="checkbox"/> Recurrent Ear Infections | | <input type="checkbox"/> Mental retardation or learning disability | |
| <input type="checkbox"/> Pneumonia | | <input type="checkbox"/> Depression / Anxiety | |
| <input type="checkbox"/> Urinary Tract Infections | | <input type="checkbox"/> Other Chronic Medical Conditions | |

Has your child ever been hospitalized? Yes No. If yes, explain _____

Previous Surgeries and dates _____

Please list any specialist your child is currently seeing and reason _____

Medications

ALLERGIES to MEDICATIONS / VACCINES: Yes No. If yes, explain _____

Currently on Medication: Yes No. If yes, list medications and dose _____

Vitamins _____ Herbal Supplements _____ Over-the-counter meds _____

Developmental / Nutrition

At what age did your child: Walk Alone _____ Sit Alone _____ Toilet Train (day) _____ Say Words _____ 1st Period (females) _____

Was your child breastfed? No Yes, how long? _____

Has your child had any unusual feeding/dietary problem? No Yes, explain _____

Current milk intake: Type _____ Amount _____ oz/day

Social History

Who lives in the household with the child? Mom Dad Siblings (# _____) Grandparents Other _____

Child's parents are married unmarried divorced other _____

Childcare: parents relatives daycare babysitter/nanny

Days per week in childcare (not with parents) _____

Do any household members smoke Yes No

How many hours per day does your child: Watching TV _____ Computer _____ Video Games _____

Child's School Name: _____ Grade: _____

Any concerns about school performance? No Yes, explain _____

Sports/Exercise: Type: _____ How often? _____ How long? _____ mins

Family History

Do any family members have any of the following conditions:

| CONDITION | MOTHER | FATHER | SIBLING | GRANDPARENT |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression/Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain all positives _____

Review of Systems (Check all that Apply)

| | |
|--|---|
| <p>Constitutional</p> <p><input type="checkbox"/> Fever/Chills <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Unexplained weight loss/gain <input type="checkbox"/> Excessive Thirst</p> | <p>Gastrointestinal</p> <p><input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> Constipation/Blood in stool</p> <p><input type="checkbox"/> Abdominal Pain</p> |
| <p>Ear, Nose, and Throat</p> <p><input type="checkbox"/> Loud Voice/Hearing Problem <input type="checkbox"/> Mouth-breathing/Smoking</p> <p><input type="checkbox"/> Ear Pain <input type="checkbox"/> Frequent Runny Nose</p> | <p>Cardiovascular</p> <p><input type="checkbox"/> Chest Pain/Palpitations <input type="checkbox"/> Tires easily with exertion</p> <p><input type="checkbox"/> Fainting</p> |
| <p>Respiratory</p> <p><input type="checkbox"/> Cough, short breath <input type="checkbox"/> Chest tightness/Wheeze</p> | <p>Genitourinary</p> <p><input type="checkbox"/> Frequent or painful urination <input type="checkbox"/> Bed Wetting frequent accidents</p> <p><input type="checkbox"/> Vaginal or Penile Discharge</p> |
| <p>Musculoskeletal</p> <p><input type="checkbox"/> Muscle pain/Weakness <input type="checkbox"/> Joint Pain/Swelling</p> <p><input type="checkbox"/> Bone Pain</p> | <p>Neurologic</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Clumsiness <input type="checkbox"/> Discharge</p> |
| <p>Other (Eye, Skin, Blood)</p> <p><input type="checkbox"/> Blurry Vision <input type="checkbox"/> Squinting <input type="checkbox"/> "Crossed eyes" <input type="checkbox"/> Itchy eyes</p> <p><input type="checkbox"/> Rashes <input type="checkbox"/> Abnormal moles <input type="checkbox"/> Abnormal Bruising/Bleeding</p> | <p>Psychiatric/Emotional</p> <p><input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> Depression <input type="checkbox"/> Sleep Problems</p> <p><input type="checkbox"/> Anger Concern <input type="checkbox"/> Concerns with Attention/Impulsivity</p> |

Reviewed by: _____ Date: _____