INITIAL PATIENT RECORD

(To be filled out by parent)

PATIENT'S NAME: _____ DATE: _____

PAST MEDICAL HISTORY

1) Who has been child's doctor until now? _____

2) Has your child had allergic reactions to any medications, foods, insect bites? ☐No ☐Yes, Which ones?

_____

3) Has your child had reactions to immunizations? ☐No ☐Yes, Which ones? _____

4) Any hospitalizations other than for birth? ☐No ☐Yes, For what? _____

_____

5) Has your child had any surgeries? ☐No ☐Yes, What? _____

_____

6) Has your child had any serious injuries? ☐No ☐Yes, What kind? _____

7) Does your child see any specialists? ☐No ☐Yes, What kind/Who? _____

_____

8) Has your child had frequent ear infections? ☐No ☐Yes

9) Any eye problems ☐No ☐Yes

10) Has he/she had any problems with teeth? ☐No ☐Yes

11) Has he/she had any problems with asthma, used inhalers, or had nebulizer treatments? ☐No ☐Yes

12) Has he/she had pneumonia? If Yes, how many times?_____ ☐No ☐Yes

13) Does he/she have a heart murmur or any heart problems? ☐No ☐Yes

14) Any problems with urination? ☐No ☐Yes

15) Any problems with diarrhea or constipation? ☐No ☐Yes

16) Have there been any seizures or other problems with the nervous system? ☐No ☐Yes

17) Any eczema, hives, or other skin conditions? ☐No ☐Yes

18) Has your child ever been anemic? ☐No ☐Yes

19) Has your child ever had high lead levels in blood? ☐No ☐Yes

20) Does your child have any developmental concerns? ☐No ☐Yes

21) Does your child have any discipline/behavior problems? ☐No ☐Yes

22) Other concerns? _____

_____

IMMUNIZATION RECORD

Do you have a record of immunizations? ☐No ☐Yes, Please give copy to receptionist.

LIST MEDICATIONS TAKEN BY CHILD AT PRESENT

Name and Dosage (if dose unknown, please list pharmacy where prescription was filled so we may call if needed)
Please include all oral, inhaled, nasal, injectable, herbal, vitamins, and over-the-counter medications

_____

_____

_____

PATIENT'S NAME: _____ DATE: _____

SOCIAL HISTORY

1) Who lives in household with your child?

- ☐ Biological mom
- ☐ Biological dad
- ☐ Step mom
- ☐ Step dad
- ☐ Grandmother
- ☐ Grandfather
- ☐ Siblings, How many? _____
- ☐ Others: _____

2) Does anyone in the household smoke? ☐No ☐Yes; If yes, where? ☐Inside home ☐Outside home ☐Vehicle

3) Do you have any pets? ☐No ☐Yes, What type(s)? _____

Where do pets stay? ☐Inside home ☐Outside home

4) What type of home do you live in? ☐ Private ☐ Apartment ☐ Condo

5) What type of heating is used in your home? ☐ Electric ☐ Gas ☐ Wood

6) Does your child attend school/daycare? ☐ No ☐Yes, Name: _____

FAMILY HISTORY

	Biological Mother	Biological Father	Siblings	Grandparents	Other
ADHD					
Anemia					
Asthma					
Autism / Asperger's					
Bipolar Disorders					
Bleeding Disorders					
Cancer (if yes, what type?)					
Celiac Disease					
Crohn's / Ulcerative Colitis / IBS					
Cystic Fibrosis					
Diabetes					
Eczema					
Hearing Loss					
Heart Attack / Stroke before age 55					
Hepatitis					
High Cholesterol					
High Blood Pressure					
Irregular Heart Beats					
Kidney Reflux					
Kidney Stones					
Lupus					
Mental Retardation					
Migraine					
Neurofibromatosis					
Obesity					
PTSD					
Schizophrenia					
Seizure / Epilepsy					
Sickle Cell Anemia / Trait					
Sleep Apnea					
TB					
Thyroid Problem					
Other genetic disorders (If yes, what?)					