PATIENT HISTORY – CHILDREN (age 12 or less)

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Medical Record # **Date:**

Last Name		**First Name**		**Middle Initial**
Date of Birth	**Age**	**Sex:** **Male** **Female**	**Primary Care Physician**	

Medications: None ☐		**Allergies:** None ☐	
Please list all medications your child takes and the dosages (including over the counter medications)		Please list allergy and type of reaction (please include medication, environmental and food allergies)	
Medication	Dosage	Item	Reaction

Family History:	Yes	No
Cancer	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Other?	☐	☐

Social History	**Yes**	**No**
Attends day care/school	☐	☐
Does anyone smoke in the home?	☐	☐
Number of siblings	___________	
Primary Caregiver	___________	

Surgery and Hospitalizations: List the date and type of operations your child has had.

Year	Operation or Reason for Hospitalization

	Yes	**No**
1). Was your child born at term (within 2 weeks of due date)?	☐	☐
A. If not- what was the gestational age in weeks? ___________		
b. Type of Delivery – circle one Vaginal C-section		
2). Where there any complications at birth (Jaundice, etc.)?	☐	☐
3). What was the birth weight? ___________		
4). What was the birth length (height)? ___________	☐	☐
5). Males – Circumcised?		
6). Has your child had any of the following?		
a. Asthma attacks?	☐	☐
b. Pneumonia?	☐	☐
c. Recurrent ear infections?	☐	☐
d. Handicap?	☐	☐
e. Illness requiring hospitalization?	☐	☐
f. Broken bones?	☐	☐
g. Chickenpox?	☐	☐
7). Developmental Delays?	☐	☐
8). ADD/ADHD?	☐	☐

BRING SHOT RECORDS TO APPOINTMENT

Provider Reviewed: __________________________ Date: _______________ Revised: 2/14