



BASIC INFORMATION

REASON FOR VISIT		TODAY'S DATE	
FIRST NAME	LAST NAME		DATE OF BIRTH
PRIMARY CARE PHYSICIAN		PREFERRED PHARMACY	
SEX AT BIRTH	MALE	FEMALE	<b>GENDER IDENTIFICATION</b> (ex. male, female, transgender, gender neutral, non-binary...)
FORM COMPLETED BY		RELATIONSHIP TO PATIENT	

HOUSEHOLD (list all people living in the child's home)

RELATIONSHIP TO CHILD	NAME	DATE OF BIRTH	HEALTH PROBLEMS

List any siblings that the child does not live with:

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CHILD'S LIVING SITUATION

BIOLOGICAL FAMILY     
 FOSTER FAMILY     
 SINGLE CUSTODY  
 ADOPTIVE PARENTS     
 JOINT CUSTODY     
 OTHER (describe) \_\_\_\_\_

If one or both parents are NOT living in the home, how often does the child see the parent? \_\_\_\_\_

BIRTH HISTORY

BIRTH WEIGHT \_\_\_\_ LBS \_\_\_\_ OZ

WAS THE BABY BORN AT TERM (37 weeks or more)?

YES / NO

HOW MANY WEEKS? \_\_\_\_\_

WHERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS?

YES / NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

WAS A NICU STAY REQUIRED?

YES / NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

DELIVERY: VAGINAL / CESAREAN

WAS THE INITIAL FEEDING: FORMULA / BREAST MILK

HOW LONG BREASTFED? \_\_\_\_\_

DID THE BABY GO HOME WITH MOTHER FROM THE HOSPITAL?

\_\_\_\_\_

DURING PREGNANCY, DID THE MOTHER:

USE PRENATAL VITAMINS? YES / NO

USE TOBACCO? YES / NO

IF YES, HOW MUCH? \_\_\_\_\_

\_\_\_\_\_

USE ALCOHOL? YES / NO

IF YES, HOW MUCH? \_\_\_\_\_

\_\_\_\_\_

USE DRUGS OR MEDICATIONS? YES / NO

IF YES, WHAT KIND AND WHEN? \_\_\_\_\_

\_\_\_\_\_



MEDICATIONS

CURRENT MEDICATIONS (include dose and frequency)

Five horizontal lines for listing current medications.

MEDICATION ALLERGIES

YES / NO / DON'T KNOW
Please list:

Five horizontal lines for listing medication allergies.

GENERAL HEALTH

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS? YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

HAS YOUR CHILD HAD ANY SURGERY? YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DO YOU FEEL YOUR FAMILY HAS ENOUGH TO EAT? YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

BIOLOGICAL FAMILY HISTORY

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING?

WHAT FAMILY MEMBER?

CHILD HEARING LOSS: YES / NO / DON'T KNOW

NASAL ALLERGIES: YES / NO / DON'T KNOW

ASTHMA: YES / NO / DON'T KNOW

TUBERCULOSIS: YES / NO / DON'T KNOW

HEART DISEASE (BEFORE AGE 55): YES / NO / DON'T KNOW

HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION: YES / NO / DON'T KNOW

ANEMIA: YES / NO / DON'T KNOW

BLEEDING DISORDER: YES / NO / DON'T KNOW

DENTAL DECAY: YES / NO / DON'T KNOW

CANCER (BEFORE AGE 55): YES / NO / DON'T KNOW

LIVER DISEASE: YES / NO / DON'T KNOW

KIDNEY DISEASE: YES / NO / DON'T KNOW

DIABETES (BEFORE AGE 55) YES / NO / DON'T KNOW

BED-WETTING (AFTER AGE 10) YES / NO / DON'T KNOW

OBESITY YES / NO / DON'T KNOW

EPILEPSY OR CONVULSIONS YES / NO / DON'T KNOW



BIOLOGICAL FAMILY HISTORY

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING?	WHAT FAMILY MEMBER?
ALCOHOL ABUSE <b>YES / NO / DON'T KNOW</b>	
DRUG ABUSE <b>YES / NO / DON'T KNOW</b>	
MENTAL ILLNESS/DEPRESSION <b>YES / NO / DON'T KNOW</b>	
DEVELOPMENTAL DISABILITY <b>YES / NO / DON'T KNOW</b>	
IMMUNE PROBLEMS, HIV OR AIDS <b>YES / NO / DON'T KNOW</b>	
TOBACCO USE <b>YES / NO / DON'T KNOW</b>	
ADDITIONAL HISTORY NOT LISTED:	

CHILD PAST HISTORY

DOES YOUR CHILD HAVE, OR HAS YOUR CHILD HAD THE FOLLOWING?

CHICKEN POX **YES / NO / DON'T KNOW**  
 WHEN: \_\_\_\_\_

FREQUENT EAR INFECTIONS **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

PROBLEMS WITH EARS OR HEARING **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

NASAL ALLERGIES **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

PROBLEMS WITH EYES OR VISION **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

ASTHMA, BRONCHITIS, BRONCHIOLITIS OR PNEUMONIA **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

ANY HEART PROBLEM OR HEART MURMUR **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

ANEMIA OR BLEEDING PROBLEM **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

BLOOD TRANSFUSION **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

HIV **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

ORGAN TRANSPLANT **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

MALIGNANCY/BONE MARROW TRANSPLANT **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

CHEMOTHERAPY **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

FREQUENT ABDOMINAL PAIN **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

CONSTIPATION REQUIRING DOCTOR VISITS **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

RECURRENT URINARY TRACT INFECTIONS **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

CONGENITAL CATARACTS/RETINOBLASTOMA **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_

CANCER **YES / NO / DON'T KNOW**  
 EXPLAIN: \_\_\_\_\_



CHILD PAST HISTORY (CONTINUED)

KIDNEY DISEASE OR UROLOGIC MALFORMATIONS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

BED-WETTING (AFTER AGE 5) YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

SLEEP PROBLEMS/SNORING YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

CHRONIC OR RECURRENT SKIN PROBLEMS (ACNE, ECZEMA) YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

FREQUENT HEADACHES YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

OBESITY YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DIABETES YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

THYROID OR OTHER ENDOCRINE PROBLEMS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

HIGH BLOOD PRESSURE YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

HISTORY OF SERIOUS INJURY/FRACTURES/CONCUSSIONS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

USE OF ALCOHOL, TOBACCO, OR DRUGS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

ADHD/ANXIETY/DEPRESSION YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DEVELOPMENTAL DELAY YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

DENTAL DECAY YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

HISTORY OF FAMILY VIOLENCE YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

SEXUALLY TRANSMITTED INFECTIONS YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

(FOR GIRLS) PREGNANCY YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_

(FOR GIRLS) PROBLEMS WITH PERIOD YES / NO / DON'T KNOW

EXPLAIN: \_\_\_\_\_ AGE OF FIRST PERIOD: \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_