Initial History

____
Name

_________________ ______________________ _________________ **M F**
Date Completed **Birth Date** **Age**

Household

If any of the parents is not living at home, how often does the child see the parent not living at home? ___________________________

Name	Relationship to patient	Birth date	Health problems

Birth History

Baby born at: _____________weeks

Birth weight __________ Birth length __________

Medications during pregnancy:

____

Delivery: ☐ Vaginal ☐ Cesarean, Why? __________________________

____

Prenatal or neonatal complications? ________________________________

____

Feeding: ☐ Formula ☐ Breast milk. For how long? ________________

Past Medical History

Allergies: ___________________________________

Medicines: ____

Surgery: _____________________________________

Hospitalizations: ____________________________________

Medical conditions: ____

Does your child have, or ever had:

	YES	NO	Explain
Chickenpox	☐	☐	____
Eyes or vision problems	☐	☐	____
Nasal allergies	☐	☐	____
Ear infections or ear/hearing problems	☐	☐	____
Dental decay	☐	☐	____
Asthma, bronchiolitis, or pneumonia	☐	☐	____
Heart problem or murmur	☐	☐	____
High blood pressure	☐	☐	____
Anemia or bleeding problems	☐	☐	____
Blood transfusion	☐	☐	____
Malignancy, chemotherapy	☐	☐	____

Past Medical History - continuation

	YES	NO	Explain
Organ transplant	☐	☐	______________________
Frequent abdominal pain	☐	☐	______________________
Constipation	☐	☐	______________________
Urinary tract infections	☐	☐	______________________
Metabolic disorders	☐	☐	______________________
Kidney problems	☐	☐	______________________
Bed-wetting (after 5 years old)	☐	☐	______________________
Sleep problem, snoring	☐	☐	______________________
Skin problems	☐	☐	______________________
Frequent headaches	☐	☐	______________________
Seizures	☐	☐	______________________
Diabetes	☐	☐	______________________
Thyroid or endocrine problems	☐	☐	______________________
Obesity	☐	☐	______________________
Fractures, head injuries	☐	☐	______________________
ADHD	☐	☐	______________________
Developmental delay, learning disabilities	☐	☐	______________________
Mood problems, anxiety, depression	☐	☐	______________________
Girls: Age of first period ___________			
Problem with her period	☐	☐	______________________

Any other significant problem ____

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Family History

	YES	NO	WHO
Hearing loss	☐	☐	______________________
Nasal allergies	☐	☐	______________________
Asthma	☐	☐	______________________
Heart disease (before 55 years old)	☐	☐	______________________
High cholesterol	☐	☐	______________________
Anemia	☐	☐	______________________
Cancer (before 55 years old)	☐	☐	______________________
Thyroid disease	☐	☐	______________________
Liver disease	☐	☐	______________________
Kidney disease	☐	☐	______________________
Diabetes (before 55 years old)	☐	☐	______________________
Bed-wetting (after 10 years old)	☐	☐	______________________
Obesity	☐	☐	______________________
Seizures	☐	☐	______________________
Mental illness, depression	☐	☐	______________________
Developmental disabilities	☐	☐	______________________
Tobacco use	☐	☐	______________________

Any other family history: ____

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