INITIAL HISTORY

Name of Patient_____ Sex: ___Male ___Female DOB___/___/____

Form Completed By_____ Relation to Patient_____ Date___/___/____

FAMILY

Are mother and father ☐ married ☐ separated/divorced, If separated/divorced, what is the patient's custody status?_____ If one or both parents are not living in the home, how often does child see that parent(s)? _____

Are there siblings living away from home? ☐ Yes ☐ No If yes, give name, age and where they live:_____

_____

CURRENT MEDICAL HISTORY

Are immunizations up to date? ☐ Yes ☐ No

Is your child currently having any medical problems? ☐ Yes ☐ No If yes, please explain _____

_____

_____

Do you currently consider your child to be in good health? ☐ Yes ☐ No If no, please explain_____

_____

_____

Current medications: _____

_____

Allergies? ☐ Yes ☐ No If yes, list what the allergy is to and the reaction noted: _____

_____

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

Does the patient have or has ever had any of the following:	Y	N	*Explain*
1. A serious medical problem?	☐	☐	_____
2. Been hospitalized or had surgery?	☐	☐	_____
3. Had a serious injury or accident?	☐	☐	_____
4. Chickenpox? When?_____	☐	☐	_____
5. Allergies, asthma, bronchitis, respiratory infections?	☐	☐	_____
6. Repeated ear infections, tubes, or any hearing problems?	☐	☐	_____
7. Problems with eyes or vision?	☐	☐	_____
8. Heart problems or a heart murmur?	☐	☐	_____
9. Anemia, bleeding problems or blood transfusion?	☐	☐	_____
10. Abdominal pain, constipation requiring doctor visits?	☐	☐	_____
11. Recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	_____
12. Bladder or kidney infections, bed-wetting after 5 years?	☐	☐	_____
13. Recurrent skin problems (acne, eczema, etc)?	☐	☐	_____
14. Headaches, seizures, other neurologic problems?	☐	☐	_____
15. Diabetes, thyroid or other endocrine problems?	☐	☐	_____

Name of Patient_____ Date____/____/_____

DEVELOPMENT *Are you concerned about the patient's...*

		Y	N	
1.	Physical development?	☐	☐	_____
2.	Mental or emotional development?	☐	☐	_____
3.	Learning ability?	☐	☐	_____
4.	Attention span or activity level?	☐	☐	_____
5.	Behavioral problems?	☐	☐	_____

FAMILY HISTORY *If a family member has, or has had any of the following problems, check the appropriate box and list the family member: M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather U-Uncle A-Aunt*

1.	☐	_____	Deafness	16. ☐ _____	Anemia/Blood disorders
2.	☐	_____	Allergies	17. ☐ _____	Diabetes before 50 years
3.	☐	_____	Drug allergies	18. ☐ _____	Thyroid or other endocrine problems
4.	☐	_____	Asthma	19. ☐ _____	Obesity
5.	☐	_____	Eczema	20. ☐ _____	Bladder/kidney
6.	☐	_____	Respiratory infections	21. ☐ _____	Stomach/GI
7.	☐	_____	Eye or visual problems	22. ☐ _____	Cancer
8.	☐	_____	Ear infections/tubes	23. ☐ _____	Epilepsy or seizures
9.	☐	_____	Tuberculosis	24. ☐ _____	Hereditary problems
10.	☐	_____	Liver disease	25. ☐ _____	Learning problems/Attention span
11.	☐	_____	Immunity problems/HIV	26. ☐ _____	Emotional/Behavioral
12.	☐	_____	High cholesterol	27. ☐ _____	Mental illness
13.	☐	_____	High blood pressure before 50 years	28. ☐ _____	Mental retardation
14.	☐	_____	Heart attack/stroke before 50 years	29. ☐ _____	Drug/Alcohol abuse
15.	☐	_____	Other heart problems	30. ☐ _____	Other

PROVIDER COMMENTS

HISTORY UPDATE *(date/initial)* *Changes in history noted in chart on day of visit.*

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____