**PLEASE TAKE A MOMENT AND TELL US ABOUT YOUR CHILD'S HEALTH HISTORY**

Date_____

Your Child's Name_____ _____ _____

First Middle Last

Date of Birth_____

Allergies_____

Previous Physician_____ Referred by_____

**YOUR CHILD'S FAMILY**

| Name | Age | Medical Problems | Physician |
|---|---|---|---|
| Child's Mother _____ | ____ | _____ | |
| Child's Father _____ | ____ | _____ | |
| Child's Brothers & Sisters_____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |

**YOUR CHILD'S BIRTH**

Birth weight_____ Hospital_____

Vaginal or C-sec_____

Mom's OB-GYN_____

Problems during pregnancy/delivery?_____

**FOR INFANTS ONLY**

What formula does patient take?_____

Do/Did you breastfeed?_____

Does child have feeding problems?_____

When was your due date?_____

When was your first prenatal visit?_____

**YOUR CHILD'S MEDICAL HISTORY**

Hospitalizations_____

Surgeries_____

Are immunizations current?_____

Medications_____

List all of your child's medical problems

_____

_____

**DO THE FOLLOWING MEDICAL PROBLEMS AFFECT THE CHILDREN OR ADULTS IN YOUR FAMILY?**

Please circle any that apply:

seizures asthma heart problems

sickle cell disease developmental delay

other_____

**YOUR CHILD'S SOCIAL HISTORY**

What school/daycare does your child attend?_____ Grade_____

If not in school/daycare, who will care for your child when you are away?_____

Child lives with?_____

Any smokers in the home?_____

Sports or extracurricular activities_____

Is there a concern that your child may be developmentally delayed?_____

Is there anything else we should know about your child's medical or family social history?_____