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Patient Name: _____ Date of Birth: _____

NEWBORN/BIRTH HISTORY

Hospital: _____ or Home Birth OB/GYN: _____

Problems during the pregnancy, delivery or in the nursery? _____

Birth Weight: _____ Birth Length: _____ Birth Time: _____

Full Term: YES NO If no, how many wks: _____ NICU stay: YES NO

Delivery: (circle one) C-SECTION VAGINAL Discharge Date: _____

Jaundice: YES NO If yes, any phototherapy (bili lights): YES NO

Hearing Screen: PASS FAIL Mother's maiden name: _____

Was Hepatitis B vaccine given in nursery: YES NO Date (if known): _____

FAMILY HISTORY

Family History: Please list family members and the chronic conditions they suffer from (such as cancer, high blood pressure, asthma, allergies, eczema, diabetes, hearing loss, genetic problems, etc.):

PAST MEDICAL HISTORY

General Health: (circle one) GOOD FAIR POOR

Surgeries: _____

Hospitalizations: _____

Serious Accidents/Injuries: _____

Specialists your child sees: _____

Allergies to medications: _____

Medications: _____

Circle below if your child suffers from any of the following:

FREQUENT EAR INFECTIONS	FREQUENT SORE THROAT/STREP INFECTIONS		SEASONAL ALLERGIES	ASTHMA	CANCER
FOOD ALLERGIES	PNEUMONIA	CROUP	BRONCHIOLITIS (RSV)	HEART PROBLEMS/MURMUR	DEPRESSION/ANXIETY
CYSTIC FIBROSIS	CHRONIC ABDOMINAL PAIN	CONSTIPATION	REFLUX	URINARY TRACT INFECTION	HEADACHES
HEARING LOSS	EYE/VISION PROBLEMS	ANEMIA/BLEEDING PROBLEMS	ECZEMA	GENETIC/CONGENITAL PROBLEMS	
SEIZURES	DIABETES	ADD/ADHD			

Other--Please describe: _____

SOCIAL HISTORY

Whom does the child live with: _____

List Siblings:

Name: _____ BROTHER SISTER Age: _____

Name: _____ BROTHER SISTER Age: _____

Name: _____ BROTHER SISTER Age: _____

Name: _____ BROTHER SISTER Age: _____

Name: _____ BROTHER SISTER Age: _____

School/Daycare: _____

Does anyone smoke at home: YES NO Pets at home: YES NO