Stanford HEALTH CARE

University HealthCare Alliance

Name _____

Date of Birth: _____

Primary Care Provider: _____

Please arrive 30 minutes before your appointment time.
Your visit will take approximately one hour to complete.

Medications Please bring all prescription medications your child is currently taking.	
Name	**Dose and Directions**

Does your child currently have or has ever had any of the following illnesses or conditions?		
C = Current P = Past		
	C	**P**
Anemia		
Anxiety/Depression		
Asthma/wheezing		
Cancer		
Chicken Pox		
Diabetes		
Frequent Ear Infections		
Hay fever/Allergies		
Head injury		
Positive TB test		
Seizure		
Sleep Apnea		
Thyroid disease		
Other		

Surgical and Hospitalization History with Dates

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Family History	Deceased? At what age:	Health problems (As an adult or a child) Including cause of death
Mother		
Father		
Sister		
Brother		
Maternal Aunt		
Maternal Uncle		
Paternal Aunt		
Paternal Uncle		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Which Physician/Specialists has your child seen?

Specialty	Provider	Specialty	Provider
Previous Primary Care		Orthopedics	
Audiologist		Physical Therapist	
Cardiologist		Psychiatrist	
Ear Nose and Throat (ENT)		Pulmonologist	
Endocrinologist		Rheumatologist	
Gastroenterologist (GI)		Surgery	
Hematologist		Urologist	
Neurology		Other	

Social History:	
Siblings: Ages	
Parent's Occupation(s):	
If applicable: If dual households, which parent(s) has legal medical decision making authority?	
If dual households, what is the average time spent at each household?	
Pets:	
Smoking at home (include smoking outside)	
Preferred name of the patient (or child)	