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** |
|  |  |
|  |  |
|  |  |

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| --- |
| **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** |  |  |

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| --- |
| **Surgical and Hospitalization History with Dates** |
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|  |

|  |  |  |
| --- | --- | --- |
| **Family History for Patient** | **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) |  |