



Name: _____ DOB: _____

Allergies: _____ Date first seen: _____

NAME	DATE OF BIRTH	HEALTHSTATUS	OCCUPATION
Mother			
Father			
Sibling			
Sibling			
Sibling			

FAMILY HISTORY

Allergy..... Y N Asthma..... Y N Bone / Joint..... Y N
 Cardiac..... Y N Endo / Joint..... Y N Genetic..... Y N
 Hematologic..... Y N Neurologic..... Y N Urinary..... Y N
 Childhood deaths..... Y N Other _____

MEDICAL HISTORY

Medical History: _____

Surgery History (Include age & type of surgery): _____

Hospitalizations (Include age, diagnosis & length of hospitalization): _____

SOCIAL HISTORY

Who does the patient live with: _____

Does the patient divide time between 2 or more households? _____

Please list any Step parents or other adults the patient lives with _____

Who has legal guardianship of the patient? Mother Father Both Other _____

List all types of pets: _____

BIRTH HISTORY (for patients 0-2 months only)

Name of Obstetrician _____

How many total pregnancies? _____ •How many live children? _____

Any difficulties during this pregnancy? Yes No _____

Any medications taken during this pregnancy? Yes No _____

Any abnormal lab or ultrasound results? Yes No _____

Any street drugs or alcohol use during this pregnancy? Yes No _____

Any medical or mental health issues during this pregnancy? Yes No _____

Name of hospital: _____

Vaginal or C-Section delivery? _____

Any complications of labor or delivery? Yes No _____

Birth Weight _____ lbs _____ oz

Did he/she have any medical problems? Yes No _____

How long did your baby stay in the hospital? _____