

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date of visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Insurance \_\_\_\_\_

Mother \_\_\_\_\_ Age \_\_\_\_\_ Health Status \_\_\_\_\_

Father \_\_\_\_\_ Age \_\_\_\_\_ Health Status \_\_\_\_\_

Siblings:	First Name	DOB	Health
Name	_____	_____	_____
Name	_____	_____	_____
Name	_____	_____	_____
Name	_____	_____	_____

**Family History (indicate family member affected)**

Allergies _____	ETOH abuse _____
Asthma _____	Substance abuse _____
Cancer _____	Hematologic _____
Cardiovascular (HTN) _____	Diabetes _____
Kidney disease _____	Seizures/Neuro _____
Other _____	Psych _____

Is child exposed to second hand smoke?  yes  no

**Birth History  n/a**

Hospital \_\_\_\_\_ Mother's blood type \_\_\_\_\_ Child's blood type \_\_\_\_\_ COOMBS \_\_\_\_\_

Gestation \_\_\_\_\_ weeks Duration of Labor \_\_\_\_\_ EDC \_\_\_\_\_ Delivery Method \_\_\_\_\_

Maternal/Neonatal Complications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birth Weight \_\_\_\_\_ Birth Height \_\_\_\_\_ Birth HC \_\_\_\_\_ APGAR1 \_\_\_\_\_ (5) \_\_\_\_\_

Feeding \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Age at discharge \_\_\_\_\_ Weight at discharge \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Medical Record #: \_\_\_\_\_

**Past Medical History**  N/A

Allergies \_\_\_\_\_

Birth History \_\_\_\_\_

Childhood Diseases \_\_\_\_\_

Surgery \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Chronic Problems \_\_\_\_\_

Medications \_\_\_\_\_

Vaccine Update \_\_\_\_\_

MMR 1. \_\_\_\_\_ Hepatitis B 1. \_\_\_\_\_  
2. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_

Varicella \_\_\_\_\_ Tetanus \_\_\_\_\_  
(or date of disease) \_\_\_\_\_ Other \_\_\_\_\_

Dental History \_\_\_\_\_

Other \_\_\_\_\_

**Lab Tests**

	Date/Results	Date/Results	Date/Results		Date/Results	Date/Results	Date/Results
HGT/HGB				LEAD			

**Current Medical History**  N/A

Diet \_\_\_\_\_ Exercise \_\_\_\_\_

Sleep \_\_\_\_\_ Substance Use \_\_\_\_\_

School \_\_\_\_\_ Steroid Use \_\_\_\_\_

Grades \_\_\_\_\_ Alcohol Use \_\_\_\_\_

College/Career Plans \_\_\_\_\_ Tobacco Use \_\_\_\_\_

Job \_\_\_\_\_ Living Situation \_\_\_\_\_

Sports/Interests/Hobbies \_\_\_\_\_

Sexual Issues \_\_\_\_\_

Menstrual History: LMP \_\_\_\_\_ Menarche \_\_\_\_\_ Problem \_\_\_\_\_

Other \_\_\_\_\_

**Interviewer** \_\_\_\_\_ **Date** \_\_\_\_\_