Patient History

Childs Name: _____ Nickname(if any): _____

Date of Birth ___/____/____ Gender: __male __Female Race/ethnicity _____

Please circle : Is child adopted Yes/ No Allergies to Medication_____

Birth History

Name and Location of Delivery Hospital:_____ ____Was it a vaginal delivery?____

Where there any problems during pregnancy/delivery (please state)? _____

Did the mother smoke/drink alcohol/ use drugs or medications during pregnancy?_____

Was the baby more than 2 weeks premature or late(if so how many weeks)? _____

What was baby's weight at birth?_____ Any problems during nursery stay? _____

Development

Did baby sit by 7 months?____ Did baby walk by 14 months?____ Did baby say 3 words by 15 months?____

Any school/developmental/discipline problems?_____

Please check off if child has any of the following problems:

__bedwetting __sleep problems __ speech problems __problems with friends/peers

Social History

Name and age of mother _____ Name and age of Father_____

Name/age and sex of all siblings_____

_____

Who lives with child?_____

Please circle: Are parents married/divorced/separated Are there any smokers in the home?_____

Any pets at home (which kind)?_____

Are there any home/domestic problems?_____

Medical/Family History Please check off whatever medical condition child or family member has had (please state what relationship to child example: sister, maternal grandmother etc...)

Wheezing/Asthma	__ patient	__ family _____
Eye/Vision problems	__patient	__family _____
Hearing Loss	__ patient	__ family _____
Frequent Ear infections	__ patient	__ family _____
Eczema/skin problems	__ patient	__ family _____
Allergies/ Hay Fever	__ patient	__ family _____
Anemia/Bleeding disorder	__ patient	__ family _____
Diabetes	__ patient	__ family _____
Seizures	__ patient	__ family _____
Kidney/Bladder problems	__ patient	__ family _____
High Blood Pressure	__ patient	__ family _____
ADD/ADHD	__ patient	__ family _____
Liver problems	__ patient	__ family _____
Mental/ Psychiatric Illness	__ patient	__ family _____
Alcohol/Drug Abuse	__ patient	__ family _____
Thyroid disease	__ patient	__ family _____
High Cholesterol	__ patient	__ family _____
Sudden/Unexplained Death	__ patient	__ family _____
Heart Disease	__ patient	__ family _____
genetic/inherited diseases	__ patient	__ family _____
cancer	__ patient	__ family _____
autism/aspergers	__ patient	__ family _____
Other_____	___ patient	__ family _____

Has your child ever been prescribed a nebulizer machine?_____

Has anyone in the family had a heart attack/heart disease under the age of 50(who)? _____

Has Child ever been hospitalized (please give date and illness)?_____

Has Child had any surgeries (please give date and type of surgery)?_____

Has the child had any serious illness or accidents?_____