PATIENT HISTORY FORM

Patient's Name: _____

Birth History

Was this child? Full Term Preterm Adopted
If preterm, how many weeks? _____ If adopted, at what age? _____
Birth Weight: _____ Length: _____
Type of delivery: _____ Obstetrician: _____
Did he/she have any problems in the newborn period? _____

Past Medical History

Please circle any illnesses your child has had and list approximate dates and/or frequency:

Anemia	Heart Murmur	Seizures
Asthma	Pneumonia	Strep throat
Chicken Pox	RSV Bronchiolitis	Urinary infections
Ear infections	Reflux (GERD)	Other: _____

List any surgeries/hospitalizations: _____
List any known allergies: _____
List all medications taken on a regular basis: _____

Family History

Has a family member ever been diagnosed with any of the following?
Please circle and list the relationship. Only include you and the **child's** other parent, siblings, grandparents, aunts, uncles, and cousins.

Anemia	Allergies	Asthma	Bleeding disorder
Cancer	Crohn's disease	Diabetes	Eczema
Emotional problems	Epilepsy	Heart Attack	High blood pressure
High cholesterol	Kidney Disease	Lazy Eye	Psoriasis
Stroke	Thyroid disease	Tuberculosis	Ulcerative Colitis
Unexplained/Sudden Death	Urinary Reflux		

Other _____

If you circled any of the above, please identify the relation: _____
. _____

Is there anything more you would like us to know about your child? _____
. _____

Person completing this form: _____