The Children's Clinic

CHILD'S NAME: _____

DATE OF BIRTH: _____ **AGE:** _____

Your name: _____

Your relationship to child: _____

Household members, name and relationship: _____

_____

_____

_____

Child's previous doctor or primary care provider: _____

Other doctors who regularly see your child: _____

_____

Ongoing Medical Issues: _____

_____

_____

_____

Medicines/Vitamins: _____

_____

Herbs/Home Remedies: _____

Allergies or reactions to (Please list):

Medicines _____

Vaccinations _____

Food _____

Other _____

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:

Delivery by ☐ Vaginal birth ☐ Caesarean

If Caesarean, why? _____

Birth weight: _____ Birth length: _____

Please indicate any medical problems during the baby's newborn period

☐ None (If premature, how early?) _____

_____

Other problems: _____

_____

PATIENT'S PAST MEDICAL HISTORY

Please describe any major medical problems and their dates: _____

_____

_____

Hospitalization or operations (with dates): _____

_____

Broken bones or severe sprains: _____

_____

Please circle any problems your child has been diagnosed with:

Asthma/Allergies/Eczema	High Cholesterol
Cancer	Inherited or Metabolic Disorder
Heart Disease	Birth Defects
High Blood Pressure	Skin Problems
Hearing Loss	Chicken Pox
Frequent Ear Infections	Tuberculosis or Positive TB test
Diabetes	Weight Concerns
Vision problems	Bone or Joint Disease
Kidney Disease	Behavior Problems
Urinary Tract Infections	Learning Disabilities
Menstrual Problems	Headaches
Gastrointestinal Problems	Seizures
Anemia	Mental Illness
Bleeding or Clotting Disorders	Head Injury or Concussion

Please indicate family members **of your child** (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

	Parent	Sib	Grand Parent	Aunt/ Uncle
Asthma/Allergies/Eczema	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Sudden Death.	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Inherited/Genetic Diseases	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐
Deafness/Hearing Loss	☐	☐	☐	☐
Diabetes.	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Vision Problems	☐	☐	☐	☐
Female Reproductive Probs	☐	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐	☐
Anemia/Bleeding/Clotting	☐	☐	☐	☐
Hepatitis/TB/Infections	☐	☐	☐	☐
Skin Disorders	☐	☐	☐	☐
Arthritis/Autoimmune Disease	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐
Seizures/ Migraines	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐
Depression/Suicide	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Kidney Disease.	☐	☐	☐	☐

Other _____

_____

FAMILY HISTORY

Please indicate any deaths of your immediate family members: _____

_____

_____