Child's Name: _____ DOB: _____ Sex: F / M
Siblings (Name/ Age): _____
Birth Hospital: _____ Delivered by: _____

Text

Family History

Please mark (X) if any of the patients immediate family members have had any of the following. Please indicate which family member(s) has marked condition

( ) Allergies ( ) Asthma
( ) Diabetes ( ) Mental Illness
( ) Heart Disease ( ) Genetic Disorders
( )Smoking ( )Cancer
( ) High Blood Pressure ( ) Other: _____
( ) Other
_____

Birth History

Type of Delivery: ( ) Vaginal ( ) C-Section
Gestational Age: _____ Birth Weight: _____
Complications @ delivery? _____
Length of hospital stay: _____
Comments: _____
_____

FEEDING
CHILDREN UNDER 1 YEAR OF AGE

( ) Breast feeding Frequency: _____
( ) Bottle feeding Frequency: _____
Type of Formula: _____
Ounces per Feeding: _____ Frequency: _____
Consumes:
( ) Solids ( ) Table Foods ( ) Uses Cup
Comments /Problems
_____
_____

Children over 1 year of age

Appetite: ( ) Good ( ) Fair ( ) Poor
( ) Feeds Self ( ) Must be coaxed or forced to eat

Pt. Likes: ( ) Meats ( ) Eggs ( ) Fruits
( )Milk ( ) Cereal ( ) Vegetables
( ) Sodas ( )Juice

Amt of milk/day: _____
( ) Skim ( ) 2% ( ) Whole
Is patient on Vitamins? : _____
Food Allergies: _____
Comment: _____

DEVELOPMENT

Please tell us at what age your baby did the following:

Smiled:	Walked:
Sat:	Spoke:
Crawled:	Used Sentences:
Stood:	Toilet Trained:
Comments:	

HABITS

( ) Poor Sleeper ( ) Speech Problems
( ) Thumb sucking ( ) School Problems
( ) Anxious ( ) Frequently Disciplined
( ) Behavior Problems ( ) Wets bed
Comments:_____
_____

ILLNESSES

General Health: ( )Good ( )Fair ( )Poor

( ) Bronchitis ( ) Chicken Pox
( ) Wheezing ( ) Kidney/Urinary Problems
( ) Frequent Colds ( ) Serious Accident
( )Ear Infections ( )Serious Illnesses
( ) Pneumonia ( ) Frequent Strep Throat
( ) Sinus Infection ( ) Hospital/Surgeries
( ) Tonsils/Adenoids Removed
Explain:
_____
_____

ALLERGIES (Medications/ Environmental)

Type/Name: _____
Reaction: _____
Type/Name: _____
Reaction: _____

Immunizations

Is the patient up to date on immunizations? _____
If you are transferring to our clinic, have you requested medical records from pervious doctor(s)? _____

Please tell us if you have any questions/ concerns: _____
_____
_____

Form Completed by: _____ Relationship to Patient: _____
Date Completed: _____