



Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Date \_\_\_\_\_

**I Present Illness/Medications – (See medication list)**

**Allergic to:**

(Age 3 and under: All Sections) (Age over three: Sections D-G)

**II Past Medical History**

**A. Mothers Prenatal Care**

Complications \_\_\_\_\_  
 Exposure to X-rays \_\_\_\_\_  
 Medications \_\_\_\_\_  
 \_\_\_\_\_

**Circle those that apply:**

Drugs/Alcohol/Tobacco \_\_\_\_\_  
 Cesarean/Forceps/Complicated Labor/Delivery \_\_\_\_\_  
 Explain \_\_\_\_\_

**B. Newborn History**

Birth weight \_\_\_\_\_  
 Premature or Full Term \_\_\_\_\_  
 Complications \_\_\_\_\_  
 Hospital of Birth \_\_\_\_\_

**C. Nutrition**

Breast/Bottle \_\_\_\_\_  
 Feedings/oz. per day \_\_\_\_\_  
 Solids \_\_\_\_\_

**D. Injuries/Poisoning**

\_\_\_\_\_

**E. Hospitalizations/Surgeries: (tubes, hernia, Tonsils, etc.)**

AGE \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_  
 \_\_\_\_\_

**F. Developmental**

Smiled at \_\_\_\_\_  
 Crawled \_\_\_\_\_  
 Sentences \_\_\_\_\_  
 Sat Alone \_\_\_\_\_  
 Walked Alone \_\_\_\_\_  
 Any concerns about development \_\_\_\_\_  
 \_\_\_\_\_  
 Performance at School \_\_\_\_\_  
 \_\_\_\_\_  
 Behavioral Difficulties \_\_\_\_\_  
 \_\_\_\_\_

**G. Childhood Diseases**

Chickenpox \_\_\_\_\_  
 Measles/Mumps \_\_\_\_\_  
 Strep/Rheumatic fever \_\_\_\_\_  
 Other \_\_\_\_\_

**III. Social History**

Who lives in home; Parents, siblings, grandparents? \_\_\_\_\_  
 Who cares for child when parent not there? \_\_\_\_\_  
 \_\_\_\_\_  
 Alcohol/Drugs used by family members? \_\_\_\_\_  
 \_\_\_\_\_  
 Exposure to Violence (self, family, other)? \_\_\_\_\_  
 \_\_\_\_\_  
 Is there a gun in the home? \_\_\_\_\_  
 Car Seats/Smoke Alarms/poison control? \_\_\_\_\_  
 Where does child sleep? \_\_\_\_\_

**IV Family History (Section III – All Patients) (parents, grandparents, brothers, sisters)**

	YES	NO
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Infant Death	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/ Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorder/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bone/Muscle/Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism/Drug Use	<input type="checkbox"/>	<input type="checkbox"/>

**V. Review of Systems(Section IV – All Patients)**

	YES	NO
<b>A. EENT</b>		
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tubes in Ears	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Cardiorespiratory</b>		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Positive TB Test	<input type="checkbox"/>	<input type="checkbox"/>
BCG	<input type="checkbox"/>	<input type="checkbox"/>
Smokers in Home	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Gastrointestinal</b>		
Vomiting/Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Stools in underwear	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Genitourinary</b>		
Wets the Bed	<input type="checkbox"/>	<input type="checkbox"/>
Pain on Urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more Frequently than usual	<input type="checkbox"/>	<input type="checkbox"/>
Toilet trained at what age	_____	_____
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Boys – good urine stream	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Reproductive</b>		
Had Sex Education	<input type="checkbox"/>	<input type="checkbox"/>
Knows Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Active	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Age at First Period	_____	_____
Periods Normal	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Neurological</b>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Musculoskeletal</b>		
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
<b>H. Hematological</b>		
Anemia/Takes Iron	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>
History of Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia/Trait	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Allergy</b>		
Tested for Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>
Reactions to:		
Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Comments:  
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Date \_\_\_\_\_ Providers Signature \_\_\_\_\_