

NAME:	DOB: <i>dd/mm/yyyy</i>	DATE:
Mother's name:	Father's name:	Other parent's name:
Who does your child live with?		

HEALTH ASSESSMENT
What is most important to you about the medical care of your child? (<i>e.g. communication, prevention, wellness planning</i>)
What specific concerns about your child would you like to address with their new clinician?

MEDICATIONS & ALLERGIES				
Please list all your child's current medications (<i>including vitamins & supplements</i>)				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
Allergies to medications and other items:				
1.			Reaction:	
2.			Reaction:	
Preferred pharmacy:		Phone:		Fax:
Address:				

SOCIAL HISTORY & LIFESTYLE		
Daycare/Nanny? <input type="radio"/> Yes <input type="radio"/> No	School:	Grade:
Any problems at home/school/daycare (<i>i.e. learning, behavioral etc.</i>)?		
Who lives at home with your child?		
Are there any pets in the home? <input type="radio"/> Yes <input type="radio"/> No If yes, type:		
Diet (<i>infants</i>): <input type="radio"/> Breastfeeding <input type="radio"/> Formula <input type="radio"/> Solid foods		
Diet (<i>children or adolescents, please describe</i>):		
Exercise or Activities		
Type:	No. of days per week:	
Type:	No. of days per week:	
Type:	No. of days per week:	
Does anyone smoke in the home? <input type="radio"/> Yes <input type="radio"/> No		
If your child is less than 4'9", does he/she use a car seat (booster seat)? <input type="radio"/> Yes <input type="radio"/> No		
If your child is under age 13, does he/she ride in the back seat of the car? <input type="radio"/> Yes <input type="radio"/> No		
Do you feel safe in your neighborhood? <input type="radio"/> Yes <input type="radio"/> No		
Are there guns in your home? <input type="radio"/> Yes <input type="radio"/> No	If yes, are they unloaded and locked away? <input type="radio"/> Yes <input type="radio"/> No	
Is there any history of abuse in your child's home or life? (<i>physical, sexual, emotional, neglect</i>)? <input type="radio"/> Yes <input type="radio"/> No		

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NAME:	DOB:
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HEALTH MAINTENANCE & PREVENTION

When was the last time your child:

Had a well-child exam?	Visited the dentist?
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Female Health

Has your child started her period? Yes (*Age*) No

Has your child had a PAP smear? Yes No

If yes, when? *mm/yyyy* Result: Normal Abnormal

Immunizations

Are your child's immunizations current? Yes No

PERSONAL MEDICAL HISTORY

Pregnancy complications:	Delivery complications:
Delivery method: <input type="radio"/> Vaginal <input type="radio"/> C-section	Birth weight:
Multiple births (<i>twins</i>): <input type="radio"/> Yes <input type="radio"/> No	

Has your child ever had any problems with the following: (If yes, please explain.)

<input type="checkbox"/> Alcohol or substance abuse:	<input type="checkbox"/> Lungs:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Metabolism (<i>diabetes, thyroid etc.</i>):
<input type="checkbox"/> Blood:	<input type="checkbox"/> Muscle, joint, bones:
<input type="checkbox"/> Digestion:	<input type="checkbox"/> Nerves and brain:
<input type="checkbox"/> Ear, nose, throat, eyes:	<input type="checkbox"/> Skin and hair:
<input type="checkbox"/> ER Visits: Type: Date:	<input type="checkbox"/> Sleep:
<input type="checkbox"/> Heart or blood vessels:	<input type="checkbox"/> Social, mental or emotional health:
<input type="checkbox"/> Hospitalizations: Type: Date:	<input type="checkbox"/> Surgeries: Type: Date:
<input type="checkbox"/> Infectious diseases:	<input type="checkbox"/> Female health (<i>menstrual problems, etc.</i>):
<input type="checkbox"/> Kidneys or bladder:	<input type="checkbox"/> Male health (<i>testicular lump/pain</i>):
<input type="checkbox"/> Learning disabilities:	<input type="checkbox"/> Other:

FAMILY MEDICAL HISTORY

Please indicate any family members who have had the following:

<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias (<i>i.e. thalassemia</i>):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease (<i>e.g. Crohn's disease</i>):	<input type="checkbox"/> Other cancer:	
<input type="checkbox"/> Any other condition that two or more relatives have?		

Please attach your child's immunization record to this form.