



For well-child checks, please also use the appropriate well-child questionnaire

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

CHILD'S PREVIOUS DOCTOR/PCP: _____

BIRTH AND PREGNANCY

What city was your child born in? _____ Name of hospital: _____

Is this your child by: Birth Adoption Step-child Other: _____

Birth weight: _____ Was your baby premature? **Y / N**

Were there any significant medical problems during your pregnancy? **Y / N**

Were there any significant complications during labor or the baby's newborn period? **Y / N**

If yes, to any of the above questions, please explain: _____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? **Y / N**

If yes, please explain: _____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY

HAS YOUR CHILD:

Had any serious medical illness? **Y / N** Had broken bones/frequent or severe sprains? **Y / N**

Had a history of asthma or wheezing? **Y / N** Had any mental or behavioral problems? **Y / N**

Ever used an inhaler or nebulizer? **Y / N** Had a positive tuberculosis skin test? **Y / N**

Had surgery? **Y / N** Been hospitalized overnight? **Y / N**

If yes, to any of the above, please explain: _____

IMMUNIZATIONS *Please bring your child's immunization records to your appointment*

Have you ever refused vaccines for your child? **Y / N**

If yes, why? _____

MEDICATIONS AND ALLERGIES

Please list current medications, vitamins, and supplements, even those used intermittently: _____

Please list allergies or reactions to medications, vaccines or foods

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Admin. use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autism	128												
Autoimmune Disorder	34												
Birth Defect/Congenital Anomaly	36												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer: Please Specify Type _____													
Cancer: Please Specify Type _____													
Depression	14												
Diabetes	81												
Eczema (Atopic Dermatitis)	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever (Allergic Rhinitis)	20												
Hearing Disorder	21												
Heart Attack/Coronary Artery Disease	13												
High Cholesterol (Hyperlipidemia)	22												
High Blood Pressure (Hypertension)	23												
Immune Disorder	24												
Inflammatory Bowel Disease (Crohns/UC)	59												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Migraine Headaches	71												
Psychiatric/Mental Illness	75												
Scoliosis	76												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 or reasons not listed above													
Other:													
Other:													

SOCIAL HISTORY: Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer	Cell Phone Number

Are your child's parents Married Unmarried Separated Divorced (If divorced or separated, when?) _____
 Child-care situation Parents Others (specify who and hours per day) _____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior
 Is violence at home a concern? Yes No Are there pets in the home? Yes No
 Are there guns in the home? Yes No Do any family members smoke? Yes No