

FAMILY CONTACT INFORMATION

Patient Live With: _____ Relationship: _____	Emergency _____
Home Phone: _____	Contact Name: _____
Home Address: _____	Emergency _____
City/State/Zip Code: _____	Contact Phone: _____
Out of Town Address: _____	Relationship to Patient: _____
City/State/Zip Code: _____	
Father's Name: _____	Mother's Name: _____
Place of Employment: _____	Place of Employment: _____
Cell Phone #: _____	Cell Phone #: _____
Work Phone #: _____ ext. _____	Work Phone #: _____ ext. _____

PATIENT / FAMILY MEMBERS

	Name	Date of Birth	Age	Social Security Number	Live with Patient
Birth Father					<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Mother					<input type="checkbox"/> Yes <input type="checkbox"/> No
All Children in order of Birth (include Patient)	1.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	3.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	4.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	5.				<input type="checkbox"/> Yes <input type="checkbox"/> No
Step Parent					<input type="checkbox"/> Yes <input type="checkbox"/> No
Step Parent					<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY MEDICAL HISTORY

	Birth Father	Birth Mother	Child 1	Child 2	Child 3	Child 4	Child 5	Grand Parents	Aunts	Uncles
Allergy, Hay Fever										
Anemia, sickle cell anemia										
Asthma or frequent respiratory infections										
Blood disease, bleeders										
Cancer										
Congenital birth defect										
Convulsions or epilepsy										
Diabetes										
Drug Sensitivities										
Ear Problems, deafness										
Eczema or other skin disorders										
Heart attack / heart disease & age of onset										
High blood pressure										
Kidney disease										
Mental illness										
Sexually transmitted disease										
Stomach or bowel disorder										
Other:										

SOCIAL HISTORY – as it relates to patient & family

Marital Status: Married Single Separated
 Divorced Remarried Widowed

How long in this area? _____

Previous From: _____

Custody: _____

Other: _____

OFFICE USE ONLY

F										
M										
1										
2										
3										
4										
5										

Reviewed By: _____ DO / MD / PA / ARNP Completed By: _____

Patient Name: _____ DOB: _____ Date: _____

ALLERGIC/ADVERSE REACTIONS		MEDICATIONS			
List any medications, food or chemicals which cause allergic or adverse reactions.	1.	List all current medications, including non-prescription drugs, fluoride, herbs & supplements	Name of Medication	Strength	How Often
	2.		1.		
	3.		2.		
	4.		3.		
	5.		4.		

ADDITIONAL MEDICAL PROBLEMS, PREVIOUS HOSPITALIZATIONS, SURGERIES OR SERIOUS INJURIES

	Date	Hospitalized	Surgery
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRENATAL HISTORY – as it relates to Mother with this child

Months and/or years to get pregnant: _____	Complications During Pregnancy?	Used the following during Pregnancy?
Prenatal care began which trimester: 1 2 3	Abnormal Ultrasound . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV test during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication <input type="checkbox"/> Yes <input type="checkbox"/> No
Dad involved during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Street Drugs. <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of total pregnancies:	STD <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of living children:	Rubella <input type="checkbox"/> Yes <input type="checkbox"/> No	Vitamins <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of miscarriages:	Other:	Other:
Number of terminated pregnancies?		

Worries or Stress? _____

BIRTH HISTORY – as it relates to Patient

Obstetrician:	Mother/Baby problems during delivery?	Baby problems during birth?
Pediatrician:	Normal Childbirth <input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of birth:	Cesarean <input type="checkbox"/> Yes <input type="checkbox"/> No	Deformities <input type="checkbox"/> Yes <input type="checkbox"/> No
Duration of pregnancy:	Breech <input type="checkbox"/> Yes <input type="checkbox"/> No	Feeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth weight:	Prolonged Labor <input type="checkbox"/> Yes <input type="checkbox"/> No	Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No
Length of stay in hospital:	Greater than 18 hours . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice. <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other:	Prematurity <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other:

PROFESSIONAL ASSISTANCE **Risks from Social Exposure** **Risks from Physical Exposure**

Does patient attend a special school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family alcohol problems? . <input type="checkbox"/> Yes <input type="checkbox"/> No	Firearms in home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient experience discipline or behavior problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family drug problems? . . <input type="checkbox"/> Yes <input type="checkbox"/> No	Firearms locked? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Smoking in home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ammunition kept separate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient seen a Psychiatrist / Psychologist? . . <input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking in car? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has patient seen a Speech Therapist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pets
Has patient been assisted by Special Teachers? . . <input type="checkbox"/> Yes <input type="checkbox"/> No		Cat(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Dog(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other:

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