LABEL

Date:_____

In order to better care for your child's health needs, we kindly ask that you provide us with the following information to the best of your ability:

Birth History:

Were there any complications during pregnancy with this child? ___yes / no___

If yes, please explain: _____

Was your child born full-term or premature? _____

If premature, at how many weeks was your child born? _____

Was your child born by vaginal delivery or cesarean section? _____

What was your child's birth weight? _____ lbs _____ oz **or** _____ kg

What was your child's birth length? _____ in **or** _____ cm

Where was your child born? _____

How many days did your child stay in the hospital after birth? _____

Did your child have any complications following his/her birth? ___yes / no___

If yes, please explain: _____

Past Medical History:

CHILDHOOD ILLNESSES: Please circle yes or no to indicate if your child has had any of the following illnesses and specify age of illness OR write "C" if your child currently has the illness.

Acne	No Yes Age_____	Hearing loss	No Yes Age_____
ADHD	No Yes Age_____	Heart murmur	No Yes Age_____
Alcohol use	No Yes How often:_____	Other heart problems	No Yes Age_____
Anxiety	No Yes Age_____	Kidney problems	No Yes Age_____
Anemia	No Yes Age_____	Liver problems	No Yes Age_____
Asthma	No Yes Age_____	Lung problems	No Yes Age_____
Behavior problems	No Yes Age_____	Mononucleosis	No Yes Age_____
Bronchiolitis	No Yes Age_____	Neurological problem	No Yes Age_____
Cancer	No Yes Age_____	Obesity/Overweight	No Yes Age_____
Constipation	No Yes Age_____	Pneumonia	No Yes Age_____
Chicken pox	No Yes Age_____	Scoliosis	No Yes Age_____
Chronic diarrhea	No Yes How often:_____	Seizures	No Yes Age_____
Croup	No Yes Age_____	Sickle cell disease	No Yes Age_____
Depression	No Yes Age_____	Sinus infection	No Yes Age_____
Developmental Delay	No Yes Age_____	Speech delay	No Yes Age_____
Diabetes Mellitus	No Yes Age_____	Urinary tract infection	No Yes Age_____
Drug abuse	No Yes Age_____	Vision problems	No Yes Age_____
Ear infections	No Yes How often:_____	Vitamin D deficiency	No Yes Age_____
Eating disorders	No Yes Age_____	Other illness:	Age_____
Eczema	No Yes Age_____	Other illness:	Age_____
Elevated cholesterol	No Yes Age_____	Other illness:	Age_____
Environmental allergies	No Yes Age_____	Other illness:	Age_____

Has your child ever been seen by a specialist?

If yes, please list the doctors' name(s) along with his/her specialty, and the month/year that your child saw him/her last:

_____

_____

Please list any medications that your child takes below, with the dosage and frequency if known: (Please include prescription medications, over the counter medications, and any vitamins or herbal supplements)

_____ _____

_____ _____

_____ _____

Is your child allergic to any medication(s)? ___yes / no___

If yes, to which medication(s)? _____

Is your child allergic to any food(s)? ___yes / no___

If yes, to which food(s)? _____

SURGERIES: Please circle yes or no to indicate if your child has had any of the following surgeries and specify age at time of surgery.

Appendix removal	No Yes Age_____	Hernia repair	No Yes Age_____	Type of Hernia:_____	
Circumcision	No Yes Age_____	Nissen procedure	No Yes Age_____		
Cleft lip/palate repair	No Yes Age_____	Removal of adenoids	No Yes Age_____		
Ear tube placement	No Yes Age_____	Removal of tonsils	No Yes Age_____		
Eye surgery	No Yes Age_____	Tooth extraction	No Yes Age_____		
Gall bladder removal	No Yes Age_____	Tracheostomy placement	No Yes Age_____		
G-tube placement	No Yes Age_____	VP shunt placement	No Yes Age_____		
Heart surgery	No Yes Age_____	Other surgery:_____	Age_____		

Family History:

Please circle yes or no to indicate if your child has any biological family members (including parents, siblings, grandparents, aunts, uncles, or cousins) with any of the following illnesses, and specify the relationship of the affected person to your child.

ADHD	No Yes Relationship:_____	Hearing loss/Deafness	No Yes Relationship:_____
Alcohol abuse	No Yes Relationship:_____	Heart problems	No Yes Relationship:_____
Anemia	No Yes Relationship:_____	Heart attack	No Yes Relationship:_____
Anxiety	No Yes Relationship:_____	HIV/AIDS	No Yes Relationship:_____
Asthma	No Yes Relationship:_____	Intellectual Disability	No Yes Relationship:_____
Arthritis	No Yes Relationship:_____	Kidney problems	No Yes Relationship:_____
Birth Defects	No Yes Relationship:_____	Learning disability	No Yes Relationship:_____
Cancer	No Yes Relationship:_____	Lupus (SLE)	No Yes Relationship:_____
Chronic lung disease	No Yes Relationship:_____	Mental illness	No Yes Relationship:_____
Depression	No Yes Relationship:_____	Miscarriages	No Yes Relationship:_____
Diabetes Mellitus	No Yes Relationship:_____	Neurological problems	No Yes Relationship:_____
Down syndrome	No Yes Relationship:_____	Obesity	No Yes Relationship:_____
Drug abuse	No Yes Relationship:_____	Seizures	No Yes Relationship:_____
Early death	No Yes Relationship:_____	Sickle cell disease	No Yes Relationship:_____
Eczema	No Yes Relationship:_____	Sickle cell trait	No Yes Relationship:_____
Elevated blood pressure	No Yes Relationship:_____	Stomach/Intestine Problems	No Yes Relationship:_____
Elevated cholesterol	No Yes Relationship:_____	Stroke	No Yes Relationship:_____
Environmental allergies	No Yes Relationship:_____	Thyroid problems	No Yes Relationship:_____
Gastrointestinal Problems	No Yes Relationship:_____	Tuberculosis	No Yes Relationship:_____
Genetic disorder	No Yes Relationship:_____	Vision Loss/Blindness	No Yes Relationship:_____

Gestational Diabetes No Yes Relationship:_____ Other:_____ Relationship:_____
Headaches No Yes Relationship:_____ Other:_____ Relationship:_____

Social History: *(The following information helps us understand your child's home situation so that we can provide the best all-around care for your child)*

Whom does your child live with? (Please circle all that apply and specify how many after the # sign)

Mother Father Brother(s) (#_____) Sister(s) (#_____) Aunt(s) (#_____) Uncle(s) (#_____)

Cousin(s) (#_____) Other adults (#_____) Other children (#_____)

What kind of home does your child live in? (Please circle all that apply)

Apartment/Condominium Townhouse Single family house Shared multi-family home Shelter

Other (Please specify:_____)

Do any of the people who live in your home smoke? ___yes / no___

Do any of the people who spend time with your child smoke? ___yes / no___

Who is/are the primary person/people who care for your child during the day? (Ex. mother, father, grandmother, babysitter,

daycare, etc.) _____

Are there any pets in your home? ___yes / no___

If yes, please specify what kind(s): _____

Are there any guns in your home? ___yes / no___

If yes, are they locked up? ___yes / no___

Has your child ever been subject to physical, sexual, or verbal abuse? ___yes / no___

If yes, from whom? _____

Has your child ever witness the physical, sexual, or verbal abuse of another person? ___yes / no___

If yes, who was the victim? _____ Who was the abuser? _____

<u>Information about child's mother:</u>

Where is child's mother from? _____
Year of birth: _____
Highest level of education: _____
Occupation: _____
Religion: _____
Year of arrival in US (if born outside US): _____
Is mother involved in child's life? _____
Has mother ever experienced post-partum depression? ___yes / no___
Has mother ever been subject to physical, sexual, or verbal abuse? ___yes / no___
If yes, from whom? _____

<u>Information about child's father:</u>

Where is child's father from? _____
Year of birth: _____

Highest level of education: _____
Occupation: _____
Year of arrival in US (if born outside US): _____
Is father involved in child's life? _____
Has father ever been subject to physical, sexual, or verbal abuse? ___yes / no___
If yes, from whom? _____