



First name: _____ Last name: _____ Today's date: _____

Nickname: _____ DOB: _____ Grade: _____

Mother's Name _____ Occupation: _____

Father's Name _____ Occupation: _____

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other: _____

Are there any siblings at home? YES ☐ NO ☐ Please list ages: _____

This child lives with ☐ Mother & Father ☐ Mother Only ☐ Father Only ☐ Other: _____

Is there anyone else that lives at home with this child? _____

Does your child attend daycare? _____ Primary language spoken at home _____

Who takes care of the child during the day or after school? _____

Child's Health History

Birth weight? _____ Please circle: Term Pre-term Post term

Is child adopted? YES NO

Complications with pregnancy? YES NO

Hospitalizations immediately after birth? YES NO

Has child missed any immunizations? YES NO

Has your child ever had surgery? YES NO

Other hospitalizations? YES NO

Any problems with recurring illnesses? YES NO

Any hearing, vision or other disabilities? YES NO

Any concerns about your child's development? YES NO

Any concerns about your child's behavior? YES NO

Has your child ever been seen by a specialist? YES NO

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

Does your child have any **ALLERGIES** to medications, foods, or other materials? YES ☐ NO ☐

If yes, to what? _____

List all **medications** your child takes (include over the counter meds, vitamins, herbal supplements and inhalers)

NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

continued on back



FAMILY HISTORY

Does anyone in the family have any history of the following? (Please circle below)

MGM/F = Maternal grandmother/father

PGM/F = Paternal grandmother/father

High blood pressure	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
High cholesterol	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Heart disease	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Stroke	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Diabetes	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Thyroid disease	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Cancer	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Bleeding/Clotting disorder	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Allergies	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Asthma	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Liver disease	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Kidney disease	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Seizures	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Migraines	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Acid reflux	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Gastrointestinal disease	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Mental problems	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Alcohol problems	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Drug problems	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Genetic disorders	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Birth defects	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF
Autism	YES	NO	MOTHER	FATHER	SIBLING	MGM	MGF	PGM	PGF

Safety/Prevention

Does your child wear a seat belt?	YES	NO	
Does your child use a car seat?	YES	NO	N/A
Does your child sit in the back seat?	YES	NO	
Does your child appropriately wear a helmet?	YES	NO	
Does your child receive regular dental care?	YES	NO	
Do you have working smoke detectors at home?	YES	NO	
Are there any firearms in the home?	YES	NO	
Is violence a concern at home?	YES	NO	
Is your child exposed to any second-hand smoke?	YES	NO	
Are there any pets at home?	YES	NO	
Do you have any other concerns about your child?			