

Child's Legal Name: _____ DOB: _____

Family Unit (list everyone living in household with child)

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History—Are any of the following present in the child's immediate family?

_____ Asthma _____ Cystic Fibrosis _____ Diabetes _____ Seizures
_____ Kidney disease _____ High Blood Pressure _____ Learning Disabilities/ADD
_____ High cholesterol/heart disease at a young age
_____ Clotting problems/anemia/sickle cell disease/inherited blood disease

Parents' marital status ___ Married ___ Divorced ___ Widowed ___ Single
Is this child exposed to passive smoke? ___ Yes ___ No
For older children—Does the child use tobacco, alcohol or recreational drugs? ___ Y ___ N
Family dentist _____
Family eye care _____
Is child in day care? ___ Y ___ N If yes, location: _____
Is child's care shared by any other household? ___ Y ___ N

Child's Medical History

Has your child been hospitalized and for what reason? _____
List any surgeries _____
Birth weight _____
Complications at Birth _____
Chronic illnesses (asthma, diabetes, etc.) _____
Any known allergies to food or medications? _____
Medications routinely taken _____

*****OFFICE USE ONLY BELOW THIS LINE*****

Allergies:

Problem List:

Daily Meds:

