



Patient Name: _____

MRN: _____

Birthdate: _____

Age: _____ M F

Household Information

Home Address _____
City, State, Zip _____ Home Phone _____

Mother: Name _____ Birthdate _____ Work Phone _____ Cell _____
Employer _____ Occupation _____
Email address: _____ Use this email for appointment confirmations

Father: Name _____ Birthdate _____ Work Phone _____ Cell _____
Employer _____ Occupation _____
Email address: _____ Use this email for appointment confirmations

Please list all those living in the child's home

Name	Relationship to child	Birthdate	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live.

Does anyone smoke? _____ Any pet? _____ Inside Outside

Does child attend daycare? _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does child see the parent/parents not in the home? _____

IN CASE OF EMERGENCY, NOTIFY: (Other than parents)

Name _____ Home phone _____ Work phone _____

Relationship to patient _____

Name _____ Home phone _____ Work phone _____

Relationship to patient _____

Name _____ Home phone _____ Work phone _____

Relationship to patient _____

PLEASE LIST THE PERSON(S) THAT YOU AUTHORIZE TO ACCOMPANY AND GIVE CONSENT FOR TREATMENT TO THE CHILD AT APPOINTMENT TIME, OTHER THAN A PARENT

Name _____ Phone _____ Relationship to Child _____

Name _____ Phone _____ Relationship to Child _____

Name _____ Phone _____ Relationship to Child _____

Signature of Parent/Legal Guardian of Minor _____ Date _____

Relationship to Patient/Minor _____ Witness by _____

Patient Name: _____

MRN: _____

Birthdate: _____

Age: _____ M F

Family History

Have any family members (including natural parents, grandparents, aunts, uncles, sisters or brothers) had the following:

- Deafness Y N Who _____ Comments _____
- Nasal allergies Y N Who _____ Comments _____
- Asthma Y N Who _____ Comments _____
- Tuberculosis Y N Who _____ Comments _____
- Heart disease (before 50 yrs old) Y N Who _____ Comments _____
- High blood pressure (before 50 yrs old) Y N Who _____ Comments _____
- High cholesterol Y N Who _____ Comments _____
- Anemia Y N Who _____ Comments _____
- Bleeding disorders Y N Who _____ Comments _____
- Liver disease Y N Who _____ Comments _____
- Kidney disease Y N Who _____ Comments _____
- Diabetes (before 50 yrs old) Y N Who _____ Comments _____
- Bedwetting (after 10 yrs old) Y N Who _____ Comments _____
- Epilepsy or convulsions Y N Who _____ Comments _____
- Alcohol abuse Y N Who _____ Comments _____
- Drug abuse Y N Who _____ Comments _____
- Mental illness Y N Who _____ Comments _____
- Mental retardation Y N Who _____ Comments _____
- Learning or attention problems Y N Who _____ Comments _____
- Immune problems, HIV, or AIDS Y N Who _____ Comments _____
- Additional family history _____

Past History

Does your child have, or has he/she ever had:

- Chickenpox Y N When _____
- Frequent ear infections Y N Explain _____
- Problems with ears or hearing Y N Explain _____
- Nasal allergies Y N Explain _____
- Problems with eyes or vision Y N Explain _____
- Asthma, bronchitis, bronchiolitis Y N Explain _____
- Pneumonia Y N Explain _____
- Any heart problem or heart murmur Y N Explain _____
- Anemia or bleeding problem Y N Explain _____
- Blood transfusion Y N Explain _____
- Frequent abdominal pain Y N Explain _____
- Constipation requiring doctor visits Y N Explain _____
- Bladder or kidney infection Y N Explain _____
- Bedwetting (after 5 years old) Y N Explain _____
- For girls, start of her menstrual periods? Y N When _____
- For girls, any problem with her periods? Y N Explain _____
- Any chronic or recurrent skin problem (acne, eczema, etc) Y N Explain _____
- Frequent headaches Y N Explain _____
- Convulsions or other neurologic problem Y N Explain _____
- Diabetes Y N Explain _____
- Thyroid or other endocrine problem Y N Explain _____
- Use of alcohol or drugs Y N Explain _____
- Learning or attention problems Y N Explain _____
- Any other chronic problem Y N Explain _____