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Patient Name (Last, First, MI)	Date of Birth	Age

Birth History (only if less than 5 years of age)

Were there any problems with pregnancy? If so, please elaborate.		
List any medications taken during pregnancy.		
Born on time? If no, please elaborate.		
☐ Vaginal Delivery ☐ Cesarean Delivery	Birth Weight	Problems during delivery
How long did the patient stay in the hospital after birth?		

Development (only if less than 5 years of age)

At what age did the patient first do the following?			
Roll Over	Sit without support	Walk	Say first word

Past Medical History

Any Hospitalizations, since birth? If so, why, and for how long?
Any major illnesses or recurrent illnesses?
Any Surgery?
Immunizations up to date? Y N

Prescription Medications

Name of Medication	Frequency	Dosage	Reason

Allergies (please list any known allergies to **medicines** or **foods**)

Social History

Who lives at home with the patient: Mother Father Brothers #_______ Sisters # _______ Other (please list)			
Pets **Y** **N**	Smokers **Y** **N**	Who	
Type Cat Dog Birds Reptiles Fish Farm/Livestock Other ______________________		Recent Travel ? **Y** **N** Where:	
Has the patient had contact with anyone who is known to have Tuberculosis, or with anyone who has had a cough for more than three months, or with someone who has had a long stay in institutions such as military, jail or hospitals? **Y** **N**			

Family History (Does anyone on either side of the family have or had any of the following?)

Asthma	Y	N	Allergies	Y	N	Diabetes	Y	N	Eczema/Sensitive skin	Y	N
Heart Problems	Y	N	Hypertension	Y	N	Seizures	Y	N	Psychiatric Pblms	Y	N
Bleeding/Anemia	Y	N	Kidney Problems	Y	N	Birth Defects	Y	N	Developmental Pblms	Y	N
Thyroid Problems	Y	N	Stomach Pblms	Y	N	Cancer	Y	N	Learning/School Pblms	Y	N