

Age 5 and up

Date: _____ NAME: _____ DOB: _____

Pharmacy: _____

Please Circle One:

Primary Language in home: English Spanish Other

Ethnicity: Not hispanic or Latino Hispanic or Latino

Race: White Asian Native Hawaiian/Pacific Islander Black/African American 2 or more races prefer not to answer

Are you interested in receiving your lab and test results electronically? Yes No

Email address: _____

Patient's Past Medical History

Prior Testing/Developmental Test	None	Yes	Test: _____
Respiratory Disease/Asthma	No	Yes	
Allergies	No	Yes	
History of Chicken Pox	No	Yes	Date: _____
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU/ Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of injury/trauma	No	Yes	Details: _____
Other Chronic problems			

Family Medical History

Please List Family Member and details below

Cancer		No	Yes
Diabetes		No	Yes
Cardiovascular disorder		No	Yes
Eye disorder		No	Yes
Ear disorder		No	Yes
Respiratory disorder		No	Yes
GI disorder		No	Yes
GU disorder		No	Yes
Musculoskeletal disorders		No	Yes
Neurologic disorder		No	Yes
Psychiatric disorder		No	Yes
SIDS		No	Yes
Skin disease		No	Yes
Other			

Patient Smoking Status (13 years & over)

(circle one)

- 1 Current everyday smoker
- 4 Never smoker
- 9 Unknown if ever smoked

- 2 Current someday smoker
- 5 Smoker, current status unknown

3 Former smoker

Surgical/Hospitalization History

Details

Non-Surgical hospitalizations	None	Yes	
Surgical History	None	Yes	
Ear Surgery	None	Yes	
Nose/Mouth/Throat Surgery	None	Yes	
Respiratory Surgery	None	Yes	
Cardiovascular Surgery	None	Yes	
GI Surgery	None	Yes	
GU Surgery	None	Yes	
Eye Surgery	None	Yes	
Orthopedic Surgery	None	Yes	
Plastic Surgery	None	Yes	
Other Surgery	None	Yes	

Child Social History

Parent information:

(circle all that apply)

- Parents together
- Lives w/mother
- Lives w/father
- Father not involved

- Father involved
- Mother involved
- Mother not involved
- Mother / Father deceased

- Guardian parents
- Same sex partners
- Other:

Child care: Circle all that apply

Name of Daycare: _____

Home w/parents _____

Private home day care _____

Sitter to home _____

Family Day care _____

Other: _____

Home occupants (list all): _____

Parents smokers: (Circle one)

No Yes Outside only

Pets what type? Inside or outside? How many? _____

Extracurricular activities: (sports, music, etc.) _____

Educational/School Information

Name of School: _____

Grade: _____

School performance: _____

Circle

Likes School

Dislikes school

Advanced Program

Honor Roll

Excellent
School issues:
None
Expelled

Good Fair
Behavior Problems
Suspended

Poor
Peer Problems Non attendance
Referred for ADHD testing by school

Menstrual History Female only
Cycle length

Age at first menstrual cycle: _____ regular? _____
Amount of flow _____