Patient Name_____ DOB_____ PCC#_____ Date today_____

MEDICAL HISTORY:

Were there any significant complications during pregnancy or delivery for your child?

_____

Does your child have any major medical problems for which they are followed by a doctor or specialist?

_____

Has your child had any surgeries or hospitalizations?

_____

Any Emergency Room visits over the past year (i.e. for concussions, broken bones, or asthma attacks)?

_____

FAMILY HISTORY:

Do either of CHILD'S parents (mom or dad), siblings (brothers or sisters), or grandparents have the following conditions for which they are followed by a doctor or treated with medications regularly:

	Yes	No	Who	Details
High cholesterol				
High blood pressure				
Clotting or bleeding disorders				
Sudden death at less than 55 years				
Stroke at less than 55 years				
Cancer				
Thyroid problems				
Childhood diabetes (Juvenile onset)				
Adult onset diabetes				
Autoimmune disease (like Rheumatoid arthritis)				
Ulcerative Colitis, Crohn's, or Celiac disease				
Eczema				
Food allergies				
Seasonal or environmental allergies				
Asthma				
Deafness (the kind you are born with)				
Mental illness (ie depression, OCD, or bipolar)				
Kidney disease or recurrent urinary infections				
Other significant medical problems				

SOCIAL HISTORY:

Does your child attend daycare? _____

Is your child in school? _____

Does anyone in your home smoke? _____

Doctor/NP Initials_____ Date_____