PATIENT NAME: _____ DOB: _____

PLEASE CIRCLE YES OR NO

FAMILY HISTORY:

ONLY INCLUDE PARENTS, SIBLINGS OF THE PATIENT, AND PATIENT'S GRANDPARENTS (PLEASE ADD MOM'S OR DAD'S SIDE)

ASTHMA YES NO RELATIONSHIP: _____

ANEMIA YES NO RELATIONSHIP: _____

DEPRESSION YES NO RELATIONSHIP: _____

DIABETES YES NO RELATIONSHIP: _____

CANCER YES NO RELATIONSHIP: _____

HEART DISEASE YES NO RELATIONSHIP: _____

(HEART ATTACK, ARRHYTHMIA, LONG QT SYNDROME, ETC.)

HIGH CHOLESTEROL YES NO RELATIONSHIP: _____

STROKE YES NO RELATIONSHIP: _____

THYROID DISEASE YES NO RELATIONSHIP: _____

MENTAL HEALTH ISSUES YES NO RELATIONSHIP: _____

(BIPOLAR, ANXIETY, SCHIZOPHRENIA, ETC.)

CONGENITAL ABNORMALITIES YES NO RELATIONSHIP: _____

(DOWN SYNDROME, SPINA BIFIDA, ETC.)

CYSTIC FIBROSIS YES NO RELATIONSHIP: _____

ANY IMMUNE PROBLEMS YES NO RELATIONSHIP: _____

(AIDS OR OTHER)

AUTOIMMUNE DISORDERS YES NO RELATIONSHIP: _____

(RHEUMATOID ARTHRITIS, FIBROMYALGIA, LUPUS, ETC.)

MUSCULAR DYSTROPHY YES NO RELATIONSHIP: _____

SICKLE CELL DISEASE YES NO RELATIONSHIP: _____

ALLERGIES TO MEDICATIONS YES NO RELATIONSHIP: _____

MEDICATION: _____

ADD/ADHD YES NO RELATIONSHIP: _____

KIDNEY DISEASE YES NO RELATIONSHIP: _____

LIVER DISEASE YES NO RELATIONSHIP: _____

SUBSTANCE ABUSE YES NO RELATIONSHIP: _____

SEIZURE DISORDER YES NO RELATIONSHIP: _____

BLOOD DISORDERS YES NO RELATIONSHIP: _____

(G6PD DEFICIENCY, FACTOR V LEIDEN, VON WILLEBRAND DISEASE, COAGULATION DISORDER, HEMOPHILIA, ETC.)

OTHER: _____ RELATIONSHIP: _____

CONTINUE TO OTHER SIDE

PATIENT PAST MEDICAL HISTORY:

BIRTH WEIGHT: _____

TERM PREGNANCY OR WEEKS GESTATION	YES	NO	WEEKS: _____
WAS DELIVERY VAGINAL OR CESAREAN SECTION? _____			
WERE THERE ANY NEONATAL OR PRENATAL COMPLICATIONS?	YES	NO	NOTES: _____
WAS THERE A NICU STAY REQUIRED?	YES	NO	NOTES: _____
INTRAUTERINE EXPOSURE TO MEDICATIONS	YES	NO	NOTES: _____
INTRAUTERINE EXPOSURE TO DRUGS	YES	NO	NOTES: _____
INTRAUTERINE EXPOSURE TO ALCOHOL	YES	NO	NOTES: _____
INTRAUTERINE EXPOSURE TO TOBACCO	YES	NO	NOTES: _____
IS YOUR CHILD IN GOOD HEALTH?	YES	NO	NOTES: _____
DEVELOPMENTAL DELAY	YES	NO	NOTES: _____
HAS YOUR CHILD HAD ANY SERIOUS MEDICAL CONDITIONS?	YES	NO	NOTES: _____
DOES YOUR CHILD HAVE ANY CHRONIC CONDITIONS?	YES	NO	NOTES: _____
HAS YOUR CHILD EVER BEEN HOSPITALIZED?	YES	NO	NOTES: _____
CHICKENPOX	YES	NO	NOTES: _____
SEASONAL ALLERGIES	YES	NO	NOTES: _____
PROBLEMS WITH HEARING OR VISION	YES	NO	NOTES: _____
ASTHMA	YES	NO	NOTES: _____
ANY HISTORY OF INJURIES (BROKEN BONES, ETC.)	YES	NO	NOTES: _____
CONCUSSION	YES	NO	NOTES: _____
ADD/ADHD	YES	NO	NOTES: _____
ABUSE	YES	NO	NOTES: _____

FOR FEMALES: AGE OF MENSTRUATION _____