Patient Name: _____ **Date of Birth:** _____

DR. SIGN OFF: _____

Personal History

Please indicate which of the following has occurred in yourself (the patient) by marking the corresponding box below. (X)

Allergies - Environmental		Migraines / Headaches	
Allergies – Food		Neurological disorder	
Allergies – Medication		Autoimmune disorders	
Eczema		Parkinson's disease	
Skin Disease		Mental Retardation	
Asthma / RAD		Delayed development	
Wheezing		Substance abuse	
Cystic Fibrosis		Mental illness/Suicide	
Lung Disease (other)		Vision/Hearing problems	
Arthritis (joint problems)		Learning disability	
Lupus (SLE)		Speech problems	
Neuromuscular disorders (myasthenia gravis, Lou Gehrig's, ALS)		Attention Deficit Hyperactivity Disorder (ADD/ADHD)	
Muscle disease		Autism	
Bone deformities/Brittle bones/Scoliosis		Psychiatric/Emotional/Behavioral problems	
Bleeding disorder		Kidney disease	
Anemia		Feeding/Eating disorders	
Sickle Cell Anemia		Liver disease	
Miscarriage/Still birth (indicate # and gestational age)		Gastrointestinal/stomach problems	
Diabetes		Cancer	
Thyroid disease		Immunological disorder	
Endocrine disease (other)		Sinus infections	
Metabolic disease		Ear infections	
Heart defects/murmur		Strep throat	
Heart attack		Congenital defects	
High blood pressure		Down's Syndrome	
High cholesterol		Weight problems	
Stroke		Surgery (including ear tubes)	
Seizure/Epilepsy			
		TURN OVER	

Patient Name: _____ **Date of Birth:** _____

Please list allergies: _____

_____

_____

Please list medications, supplements and vitamins you are taking: _____

_____

_____

_____

Comments: _____

_____

_____

_____

For Pediatric Patients only ***(this section for children ages 3 years and younger):***

Birth History

Gestational age at birth: _____
Birth weight: _____
Birth length: _____
Health concerns as a newborn: NO YES
Infections during pregnancy: NO YES
Pregnancy complications: NO YES

Days in nursery: _____
Hospital of birth: _____
Vaginal delivery or C-section delivery
Labor or delivery complications: NO YES
Oxygen required at delivery: NO YES
Infant feeding problems: NO YES

Developmental History

(Please write at what age your child achieved the following milestone)

Smiling: _____
Rolling over completely: _____
Sitting alone: _____
Crawling: _____
Saying first words: _____

Waving bye-bye: _____
Walking: _____
Riding a tricycle: _____
Speaking in sentences: _____

Developmental delays or concerns: _____

_____

_____

TURN OVER