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Patient History Information
Age 13 months to 4 years

Date ___________________________________

Patient Name ____________________________ Date of Birth ____________________________

Mother's Name ___________________________ Occupation _____________________________

Father's Name ____________________________ Occupation _____________________________

Name of School / Daycare____

Patient's Past Medical History
Where has your child gone for check-ups until now? _____________________________________

Date of last check-up? ____

Preferred Pharmacy for prescriptions: ____
List any of the following:
Serious illness/injury ____

Hospitalizations/operations ____

Current medications ____

Allergic reactions ____

Immunization reactions ____

Has your child had problems with:
eyes ___________ ears _____________ teeth ___________ wheezing_____ ___________
asthma _________ chronic cough ____ behavior ________ urination _________________
constipation ____ diarrhea __________ seizures ________ skin rashes _______________
anemia _________ chronic runny nose __________________

Family History
Who lives in the home? ____

Are parents: single ____ married ____ divorced ____ living together ____

Sibling's name _____________________________________ DOB ____ Healthy? _______________

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Sibling's name _____________________________________ DOB ____ Healthy? _______________

Do any close relatives (mom, dad, siblings, grandparents) have:
asthma/allergies _________ cystic fibrosis __________ heart disease _________ stroke _______
high cholesterol _________ birth defects ___________ bleeding disorders ____ sickle cell ___
high blood pressure _____ diabetes ______________ emotional problems ___ seizures ______
irregular heart rate _______

Safety/Environment
Do you live in a : house ____ apartment ____ mobile home ____ other ___________________

Have you ever lived in a building built before 1960? ____

Is there a working smoke detector on each floor of your home? ____________________________

Does your child always use a car seat or seatbelt when riding in a car? _______________________

Does anyone in the home smoke? ____

Are there problems with the condition of the home? (peeling paint, insects, rodents) _____________