WHOLE CHILD
PEDIATRICS

WELCOME TO OUR PRACTICE

Form Completed By/Relationship to Patient	Patient Name
	Birth Date Age
Today's Date	Male Female
Patient Social Security Number	Home Phone Number

Primary Address	City	State	Zip

Mother Cell Number	Father Cell Number	Mother Work Number	Father Work Number

Email Address	Fax Number
Referred By	

HOUSEHOLD

Please list all those living in the child's house

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names ages and where they live________________________________

____

If mother and father are not living together, or if child does not live with parent, what is the child's custody status? __________

____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home? ____________

____

BIRTH HISTORY

Birth Weight______ lbs ______oz.
Was the baby born at term? ◻ Yes ◻ No ◻ Early ◻ Late
If early, how many weeks gestation? ________________
Did mother have any illness or problem with her pregnancy?
◻ Yes ◻ No Explain ____________________________
During pregnancy, did mother: Smoke ◻ Yes ◻ No
Use drugs or medications ◻ Yes ◻ No
What_____________________When_______________

Was the delivery ◻ Vaginal or ◻ Cesarean?
If cesarean, why? ______________________________
Did your baby have any problems right after birth?
◻Yes ◻ No Explain______________________________
____
Was initial feeding ◻ Breast or ◻ Bottle?
Did your baby go home with mother from the hospital?
◻Yes ◻ No Explain______________________________
____

GENERAL

Do you consider your child to be in good health?	◻ Yes ◻ No Explain________________
Does your child have any serious illness or medical condition?	◻ Yes ◻ No Explain________________
Has your child had any serious injuries or accidents?	◻ Yes ◻ No Explain________________
Had your child had any surgery?	◻ Yes ◻ No Explain________________
Has your child ever been hospitalized?	◻ Yes ◻ No Explain________________
Is your child allergic to any medicine or drugs?	◻ Yes ◻ No Explain________________
Is your child allergic to any foods?	◻ Yes ◻ No Explain________________

Development

Are you concerned about your child's physical development? ◻ Yes ◻ No Explain________________

Are you concerned about your child's mental or emotional development? ◻ Yes ◻ No Explain________________

Are you concerned about your child's attention span? ◻ Yes ◻ No Explain________________

If your child is in school:

What Grade?________________

Name of School:________________

How is his/her behavior in school?________________

Has he/she failed or repeated a grade in school? ________________

How is he/she doing in academic subjects?________________

Is he/she in special or resources classes?________________

Family History

Have any family members had the following:

Condition				
Deafness	◻ Yes	◻ No	Who________	Comments________
Nasal allergies	◻ Yes	◻ No	Who________	Comments________
Asthma	◻ Yes	◻ No	Who________	Comments________
Tuberculosis	◻ Yes	◻ No	Who________	Comments________
Heart disease or Stroke (before age 50)	◻ Yes	◻ No	Who________	Comments________
High blood pressure (before age 50)	◻ Yes	◻ No	Who________	Comments________
High cholesterol	◻ Yes	◻ No	Who________	Comments________
Anemia	◻ Yes	◻ No	Who________	Comments________
Bleeding disorder	◻ Yes	◻ No	Who________	Comments________
Liver disease	◻ Yes	◻ No	Who________	Comments________
Kidney disease	◻ Yes	◻ No	Who________	Comments________
Diabetes (before 50 years old)	◻ Yes	◻ No	Who________	Comments________
Cancer (indicate type and age of onset)				
Obesity				
Bed wetting (after 10 years old)	◻ Yes	◻ No	Who________	Comments________
Epilepsy or convulsions	◻ Yes	◻ No	Who________	Comments________
Alcohol or drug abuse	◻ Yes	◻ No	Who________	Comments________
Death before 50 years old	◻ Yes	◻ No	Who________	Comments________
Mental illness	◻ Yes	◻ No	Who________	Comments________
Developmental Delays	◻ Yes	◻ No	Who________	Comments________
Immune problems, HIV/AIDS	◻ Yes	◻ No	Who________	Comments________

Additional family history ________________

____

____

Past History

Does your child have or has he/she ever had:

Condition			
Chickenpox	◻ Yes	◻ No	When ________
Frequent ear infections	◻ Yes	◻ No	Explain ________
Problems with ears or hearing	◻ Yes	◻ No	Explain ________
Nasal allergies	◻ Yes	◻ No	Explain ________
Problems with eyes or vision	◻ Yes	◻ No	Explain ________
Asthma, bronchitis, bronchiolitis, or pneumonia	◻ Yes	◻ No	Explain ________
Any heart problem or heart murmur	◻ Yes	◻ No	Explain ________
Anemia or bleeding problem	◻ Yes	◻ No	Explain ________

Blood transfusion ☐ Yes ☐ No Explain ______________________________
Frequent abdominal pain ☐ Yes ☐ No Explain ______________________________
Constipation requiring doctor visits ☐ Yes ☐ No Explain ______________________________
Bladder or kidney infections ☐ Yes ☐ No Explain ______________________________
Bed wetting (after 5 years old) ☐ Yes ☐ No Explain ______________________________

(For girls) Has she started her menstrual period ☐ Yes ☐ No When ______________________________
(For girls) Are there problems with her periods? ☐ Yes ☐ No Explain ______________________________
Any chronic or recurrent skin problems (acne, eczema, etc.) ☐ Yes ☐ No Explain ______________________________
Frequent headaches ☐ Yes ☐ No Explain ______________________________
Convulsions or other nenrologic problems ☐ Yes ☐ No Explain ______________________________
Diabetes ☐ Yes ☐ No Explain ______________________________
Thyroid or other endocrine problems ☐ Yes ☐ No Explain ______________________________
Any other significant problems ☐ Yes ☐ No Explain ______________________________
Use alcohol or drugs ☐ Yes ☐ No Explain ______________________________

Is your child on any current medications? ☐ Yes ☐ No
If Yes, please list: ______________________________

____

____

Other Medical Specialists

Please list any other medical specialists that your child sees

Name	Type of Specialty

Authorization For Treatment

In the event that I, (name of parent/guardian)______________________________ am unable to accompany my child/children listed above, I authorize the following individual(s) to give permission for minor treatments in my absence:

Name	Relationship

Emergency Contact Information

Name______________________________

Relationship to Child______________________________

Phone Number Best to Be Reached at____

PHARMACY INFORMATION

Pharmacy Name____

Address____

Phone Number____

INSURANCE INFORMATION

Name of Insurance____________________ ID#____________ GRP#____________

Policy Holder Name____

Employer____

Employer Address____

CURRENT PEDIATRICIAN______________________________ **TELEPHONE**____________