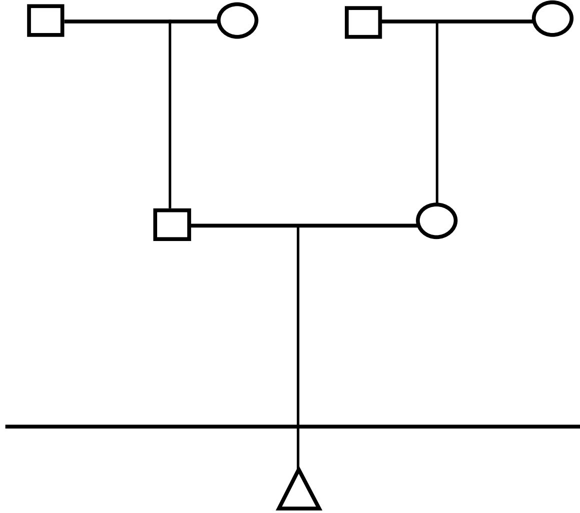
NAME: **DOB:**

Family Diagram (please leave blank for staff to complete)



Family History (significant medical problems: blood pressure, diabetes, heart disease, asthma, mental health, other)

Patient's:	Age	Alive?	Significant Health Problems
Mother		Yes / No	
Mother's Father		Yes / No	
Mother's Mother		Yes / No	
Father		Yes / No	
Father's Father		Yes / No	
Father's Mother		Yes / No	
Sister/Brother		Yes / No	
Sister/Brother		Yes / No	
Sister/Brother		Yes / No	
Sister/Brother		Yes / No	

Hospitalizations/Operations/Surgeries/Significant Injuries

Date	Medical Problem/Diagnosis	Hospital/Location

Medication Allergies/Allergic Reactions/Food Allergies

Medicine/Food/Other	Allergic Reaction	Age

Medications (please list all including herbals/homeopathic)

Medication	Dose	Diagnosis

Birth/Delivery/Infancy (circle or fill in)

Vaginal / C-section	Birth Weight	Full-term / Premature
Colic Yes / No	Breast fed Yes / No	How long?
Complications Pregnancy/Labor/Delivery/Infancy		

Safety/Injury Prevention (answer as appropriate for age)

Tobacco in house	Yes / No	Carseat/seatbelt use	Yes / No
Swimming pool	Yes / No	Adults (**all**) use seatbelts	Yes / No
Firearms in house	Yes / No	Smoke alarm/detector	Yes / No
Ipecac in house	Yes / No	Helmet, bike/skates/ski	Yes / No
House hot water temp?		Parents CPR trained	Yes / No
Discussed abuse/ appropriate touch with your child			Yes / No

Health Screening (answer as appropriate for age)

Immunizations up to date?		Yes / No / Unsure	
Flouride given daily	Yes / No	Dental appt past year	Yes / No
Hearing exam	Yes / No	Vision screening	Yes / No
Tobacco use	Yes / No	Chew / Snuff / Smoke	
Alcohol use	Yes / No	How often?	
Drug use	Yes / No	How often?	
Sexually active	Yes / No	Birth control / STD safety	Yes / No