



Patient Name \_\_\_\_\_ RNA \_\_\_\_\_

Reason for visit \_\_\_\_\_ Date \_\_\_\_\_

Primary Pediatrician \_\_\_\_\_

**CHILD DEVELOPMENT:** Please indicate the approximate age your child performed the following:

All Normal

Smiled \_\_\_\_\_ Rolled over \_\_\_\_\_ Sat up without help \_\_\_\_\_ Walked \_\_\_\_\_ Walked up stairs \_\_\_\_\_

Spoke first words \_\_\_\_\_ Spoke words besides Mama or Dada \_\_\_\_\_ Was potty trained \_\_\_\_\_

Has the child ever...

Had a seizure?  Yes  No

Suffered a head trauma?  Yes  No

Had meningitis or encephalitis?  Yes  No

Used alcohol or drugs?  Yes  No

Been physically, sexually or emotionally abused?  Yes  No

Review of Systems: Please note those that apply:

Yes No

Abdominal pains

Abnormal growth

Aggressive

Allergies

Anemia

Anxiety

Asthma

Back pain

Behavior problems

Birthmark

Chest pain

Chills

Chokes easily

Clumsy

Poor coordination

Any other concerns?

Yes No

Constipation

Cough

Daydreaming

Depression

Diarrhea

Dizziness

Easy bruising

Excessively sleepy

Faint/pass out

Fatigue

Fever

Frequent falls

Headache

Heart murmur

Hostile/Angry

Yes No

In trouble at school

Insomnia

Joint pain/ swelling

Nasal congestion

Neck pain

Numbness/tingling

Pain in arms/ legs

Pain with urination

Problems with  
behavior

Reactive Airway  
Disease

Shortness of breath

Shy

Skin rash

Yes No

Speech problems

Stares off into space

Tremor

Trouble hearing

Trouble learning

Trouble seeing

Trouble sleeping

Vomiting

Weakness

Weight change

Wets self during the  
day

Wets self during sleep

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**BIRTH HISTORY:** Check all that apply

Birth weight \_\_\_\_\_

Problems with pregnancy:  Infection  Fever  High blood pressure  
 Diabetes  Smoked  Drank alcohol  Used street drugs

Delivery:  Vaginal  Cesarean (C-Section)Problems with delivery?  No  Yes \_\_\_\_\_Birth was:  Full term  Late  Early (How many weeks? \_\_\_\_\_)

Problems as newborn:  Jaundice  Breathing  Infection  Seizure  
 Heart  NICU stay  Feeding  Birth defect \_\_\_\_\_

**MEDICAL HISTORY:** Check or fill in as indicatedHospitalization:  No  Yes, for what? \_\_\_\_\_Surgery:  No  Yes, for what? \_\_\_\_\_Past medical problems / illness ( Please include anything your doctor follows your for):  
 \_\_\_\_\_Immunizations up to date:  No  YesTests performed:  MRI  CT scan  Spinal tap  Genetics  EEG/Brain wave test

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_ Epi-Pen:  No  Yes**FAMILY MEDICAL HISTORY:** Check all that apply and write in relationship of **family member** to patient. Mental retardation \_\_\_\_\_  Birth defects \_\_\_\_\_  Attention Deficit Disorder (ADD) \_\_\_\_\_ Learning difficulties \_\_\_\_\_  Headaches \_\_\_\_\_  Depression \_\_\_\_\_ Bipolar Disorder \_\_\_\_\_  Anxiety \_\_\_\_\_  Stroke \_\_\_\_\_ Behavior problems \_\_\_\_\_  Migraines \_\_\_\_\_  Seizures with fever \_\_\_\_\_ Speech problems \_\_\_\_\_  Fainting spells \_\_\_\_\_  Seizures without fever \_\_\_\_\_ Muscle problems \_\_\_\_\_  Tics \_\_\_\_\_  Death in infancy or childhood \_\_\_\_\_ Any other medical illnesses not listed which run in the patient's family? \_\_\_\_\_ Mother's health problems \_\_\_\_\_ Father's health problems \_\_\_\_\_ Brother or sister's health problems \_\_\_\_\_**SOCIAL HISTORY:**

Members of household \_\_\_\_\_

Current grade placement \_\_\_\_\_ Grades repeated \_\_\_\_\_ Name of School \_\_\_\_\_

Number of brothers \_\_\_\_\_ number of sisters \_\_\_\_\_ Pets (types and numbers) \_\_\_\_\_

Does patient receive physical therapy?  No  Yes Occupational therapy?  No  Yes Speech therapy  No  Yes

Mother: Age \_\_\_\_\_ Occupation \_\_\_\_\_ Married / Single / Divorced / Separated

Father: Age \_\_\_\_\_ Occupation \_\_\_\_\_ Married / Single / Divorced / Separated