



PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ EXAM. DATE \_\_\_\_\_

### FAMILY HISTORY

1. Are the parents, brothers and sisters in good health? Yes No \_\_\_\_\_  
 Age of Mother \_\_\_\_\_ Father \_\_\_\_\_ Coparent \_\_\_\_\_ Sisters \_\_\_\_\_ Brothers \_\_\_\_\_
2. Does anyone in the family have:
 

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression
<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bipolar Disorder (Manic-Depressive)
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Obsessive-Compulsive Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Milk Intolerance	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Prolonged Bed-wetting
3. Has anyone in the family had any of these before age 50:
 

<input type="checkbox"/> Heart disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Emphysema
4. Do any other health problems run in the family? \_\_\_\_\_

### SOCIAL HISTORY

5. Do other people live with you and this child? No Yes \_\_\_\_\_  
 Other Parent     Siblings     Adults     Children
6. Does the mother/coparent work outside the home? No Yes \_\_\_\_\_  
 Occupation: \_\_\_\_\_
7. Does the father/coparent work outside the home? No Yes \_\_\_\_\_  
 Occupation: \_\_\_\_\_
9. Do you have pets or livestock? Types: \_\_\_\_\_ No Yes \_\_\_\_\_
9. Has there been any recent travel? No Yes \_\_\_\_\_

### REVIEW OF SYSTEMS

Please circle any of these areas that are or have been problems for your child:

- Headaches, head injuries, loss of consciousness, seizures
- Eyes, vision, ear infections, hearing, nosebleeds, sinuses, mouth, teeth
- Neck, lymph nodes, throat, choking, thyroid
- Heart, heart murmurs, irregular heart beats
- Chest, lungs, asthma, wheezing, cough, trouble breathing
- Appetite, stomach aches, digestion, diarrhea, vomiting, constipation
- Genitals, urinary tract, bladder or kidney problems or infections
- Muscles, joints, bones, strength
- Balance, coordination, reflexes
- Skin, rashes, itching, scarring, birthmarks
- Behavior, personality, attention span, speech, habits, sleep