Providence
Medical Group

Child's Name: _____
Date of Birth: *(mm/dd/yyyy)*: _____
Allergies:_____

Birth History	
Birth Hospital	
Birth weight	
Born vaginally or by C-section? If C-section, why?	
Born on time, early or late? If early, how many weeks gestation?	
Any problems or illnesses during pregnancy or delivery?	
Any problems right after birth?	
Any problems right after birth?	

	Yes/no	Comments
Any major injuries (If yes, what?)		
Any hospitalizations (If yes, what for and at what age?)		
Immunizations up to date?		

Medical History--has your child had any of the following conditions?	Yes	No	Age of onset	Comments
ADHD				
Anxiety				
Asthma				
Recurrent bladder infection / UTI				
Cerebral palsy				
Congenital heart disease				
Constipation				
Depression				
Developmental delay				
Diabetes mellitus				
Eczema				
Environmental Allergies				
Hearing loss				
Heart murmur				
Inflammatory bowel disease (Crohn's disease, Ulcerative colitis)				
Migraine headaches				
Pneumonia				
Recurrent ear infections				
Scoliosis				
Seizures				
Varicella (chicken pox)				

Medical History--has your child had any of the following conditions?	Yes	No	Age of onset	Comments
Vision Problems				
Any other conditions your child has that are not listed above:				

Surgical History--Has your child had any of the following surgeries?	Yes	No	Date (Approx)	Comments
Adenoidectomy				
Appendectomy				
Ear tubes				
Tonsillectomy				
Any other surgeries:				

Family History

You may use the following abbreviations to describe Child's Relatives: Dad, Mom, Bro, Sis

On Mom's side:
MU (maternal uncle)
MA (maternal aunt)
MGF (maternal grandfather)
MGM (maternal grandmother
MC (maternal cousin)

On Dad's side:
PU (paternal uncle)
PA (paternal aunt)
PGF (paternal grandfather)
PGM (paternal grandmother)
PC (paternal cousin)

Does anyone in the family have any of the following conditions?	Yes	No	Relationship to child	Comments
Allergies				
Arthritis				
Asthma				
Autoimmune disease				
Birth Defects				
Bleeding problems				
Cancer				
Clotting disorder (any blood clots in legs, arms, lungs)				
Depression				
Developmental delay				
Diabetes				
Early Death				
Eczema				
Hearing loss				
Heart disease				
High blood pressure				
High cholesterol				
Inflammatory bowel disease				
Kidney disease				
Learning disabilities				
Mental illness				
Migraine headaches				

Does anyone in the family have any of the following conditions?	Yes	No	Relationship to child	Comments
Seizures				
Stroke				
Substance abuse				
Thyroid Disease				
Tuberculosis				
Vision loss				
Other (See Comment)				
Check here if no family history of any of the above:				

Social History	
Who lives with your child?	
Names of parent(s)/guardian	
Primary language spoken at home	
Occupations of parent(s)/guardian	
Does your child spend time with another caregiver?	Yes/No
If yes, who is the caregiver?	
Occupations of the caregiver(s)	
Does your child have siblings?	Yes/No
If yes, how many?	
Names of sibling(s)	
Do you have any pets?	Yes/No
If so, what kind?	
Is your child in daycare?	Yes/No
Is your child in school?	Yes/No
If yes, what grade is your child in school?	
Does your child have an IEP at school?	Yes/No
Is your child in physical therapy, occupational therapy or speech therapy?	Yes/No
If yes, which therapies and is the therapy at school, a clinic or at home?	PT/OT/ST School/clinic/home
Is your child exposed to anyone who smokes or vapes?	Yes/No

MEDICATIONS (Include over the counter and herbal medications)	DOSE (Strength, # of pills or drops)	ROUTE (by mouth, inhaled, on skin)	Frequency (how often)
Example: hydrocortisone	*2.5%*	*To skin*	*Twice daily as needed*