**Date:** ____________________

**Patient Name:** ________________________________________ **DOB:** ______________________________

**Preferred Pharmacy Information**

Pharmacy Name: ____________________________________________ Phone #: _______________________

Address/Location: ___________________________________________________________________________

**Current Medical History**

Is your child having any medical problems? □ Yes □ No

Current Medications:

Drug Allergies? □ Yes □ No

. . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Past Medical History**

*Does the patient have or has ever had any of the following:*

1. had 3 or more ear infections, or required tubes? □ Yes □ No ___________________________________
2. allergies, asthma, respiratory infections? □ Yes □ No ___________________________________
3. any hospitalizations or surgeries? □ Yes □ No ___________________________________
4. had chickenpox? When? ___________ □ Yes □ No ___________________________________
5. trouble with eyes or vision? □ Yes □ No ___________________________________
6. any urinary infections? □ Yes □ No ___________________________________
7. problems with headaches? □ Yes □ No ___________________________________
8. any seizures or other neurological problems? □ Yes □ No ___________________________________
9. hearing problems? □ Yes □ No ___________________________________
10. heart murmur or other heart problems? □ Yes □ No ___________________________________
11. skin problems (acne, eczema, etc)? □ Yes □ No ___________________________________

***Development*** *Are you concerned about…*

1. physical development? □ Yes □ No ___________________________________
2. emotional or mental development? □ Yes □ No ___________________________________
3. learning ability? □ Yes □ No ___________________________________
4. activity level or attention span? □ Yes □ No ___________________________________

***If the patient is in school, has he or she had….***

1. any tutoring outside of school? □ Yes □ No ___________________________________
2. placed in a resource class? □ Yes □ No ___________________________________
3. to repeat a grade? □ Yes □ No ___________________________________
4. psychological or educational testing? □ Yes □ No ___________________________________
5. behavioral problems? □ Yes □ No ___________________________________

**Maternal and Newborn History**

***Pregnancy***

1. Did the mother have an illness during her pregnancy? □ Yes □ No ___________________________________
2. Did the mother have excessive wt. gain? □ Yes □ No ___________________________________
3. Did the mother have toxemia? □ Yes □ No ___________________________________
4. Did the mother smoke or use drugs or alcohol? □ Yes □ No (if yes please list which one/s)

_____________________________________________________________________________

_____________________________________________________________________________

***Birth***

Birth weight ___________ Length ___________ Was the baby born late or early? _____________

If early, how many weeks? ____________________________

Was the delivery complicated? □ Yes □ No Explain below….

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

***Newborn*** *check any of the following problems that the child had:*

□ feeding problems? Did the baby have breast or formula? __________________

□ weight gain? □ colic? □ jaundice? □ reflux? □ none

***Family Medical History—Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters).***

| | | *Relationship* | *Age at onset* |
|---|---|---|---|
| | High Blood Pressure | | |
| | High Cholesterol | | |
| | Heart Disease | | |
| | Stroke | | |
| | Migraines | | |
| | Seizures/Convulsions | | |
| | Diabetes | | |
| | Bleeding/Blood-clotting Disorder | | |
| | Allergies | | |
| | Asthma | | |
| | Thyroid Problems | | |
| | Osteoporosis | | |
| | Psychiatric Disorder/Mental Illness | | |
| | Alzheimer's/Dementia | | |
| | Cancer - type: | | |
| | Other: | | |
| | Other: | | |