

Medical Information Summary

Today's Date ____/____/____

New Patient Established Patient

Child's Full Name _____ Referred by _____

Child's Date of birth ____/____/____ Child's Sex M F Doctor (circle) McClellan Miller Niland Tansky

<p>Pregnancy/Birth History (Complete if child <5 yrs old or significant history)</p> <p><input type="checkbox"/> Unknown prenatal and/or birth history Pregnancy Complications:</p> <p>Mother's age at delivery _____ Month prenatal care began _____</p> <p>Pregnancy Complications: <input type="checkbox"/> Medications _____ <input type="checkbox"/> Infections _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Multiple Gestations _____ <input type="checkbox"/> Other _____</p> <p>During pregnancy, the child's mother: <input type="checkbox"/> Smoked--How much? _____ <input type="checkbox"/> Drank alcohol--How much? _____</p> <p>Birth/Newborn Complications/: <input type="checkbox"/> Cesarean <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Premature? - How early? _____</p>	<p>Child's Medical History <input type="checkbox"/> Unknown</p> <p>Hospitalizations: <input type="checkbox"/> No Significant Medical History</p> <p>_____ Age _____ _____ Age _____</p> <hr/> <p>This Child has been DIAGNOSED with:</p> <table style="width: 100%; border: none;"> <tr><td><input type="checkbox"/> ADD/ADHD</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Allergies/Hay fever</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Asthma</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Autism</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Bipolar Disorder</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Blood Disorder/Sickle Cell</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Broken Bones--Detail below</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Cancer-Type _____</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Chicken Pox</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Constipation</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Depression</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Developmental Delay</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Diabetes</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Frequent Ear Infections</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Headaches/migraines</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Learning Disability</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Menarche</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Pneumonia</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Scoliosis (curved spine)</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Seizures/epilepsy</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Skin Issues</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Stomach Problems</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> UTI/Bladder infection</td><td>Age _____</td></tr> <tr><td><input type="checkbox"/> Other</td><td>Age _____</td></tr> </table> <p>_____</p> <p>_____</p>	<input type="checkbox"/> ADD/ADHD	Age _____	<input type="checkbox"/> Allergies/Hay fever	Age _____	<input type="checkbox"/> Asthma	Age _____	<input type="checkbox"/> Autism	Age _____	<input type="checkbox"/> Bipolar Disorder	Age _____	<input type="checkbox"/> Blood Disorder/Sickle Cell	Age _____	<input type="checkbox"/> Broken Bones--Detail below	Age _____	<input type="checkbox"/> Cancer-Type _____	Age _____	<input type="checkbox"/> Chicken Pox	Age _____	<input type="checkbox"/> Constipation	Age _____	<input type="checkbox"/> Depression	Age _____	<input type="checkbox"/> Developmental Delay	Age _____	<input type="checkbox"/> Diabetes	Age _____	<input type="checkbox"/> Frequent Ear Infections	Age _____	<input type="checkbox"/> Headaches/migraines	Age _____	<input type="checkbox"/> Learning Disability	Age _____	<input type="checkbox"/> Menarche	Age _____	<input type="checkbox"/> Pneumonia	Age _____	<input type="checkbox"/> Scoliosis (curved spine)	Age _____	<input type="checkbox"/> Seizures/epilepsy	Age _____	<input type="checkbox"/> Skin Issues	Age _____	<input type="checkbox"/> Stomach Problems	Age _____	<input type="checkbox"/> UTI/Bladder infection	Age _____	<input type="checkbox"/> Other	Age _____
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<p>Child's Family History <input type="checkbox"/> Unknown</p> <p>Check the diagnoses given to <u>the child's</u> relatives. Specifically--siblings, parents, grandparents, cousins, aunts or uncles.</p> <p><input type="checkbox"/> No significant family history</p> <p><input type="checkbox"/> ADD</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Blood Disorder/Sickle Cell</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Celiac Disease</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Gastrointestinal disorder</p> <p><input type="checkbox"/> Heart disease <u>before age 55</u></p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> Learning Disability</p> <p><input type="checkbox"/> Mental retardation</p> <p><input type="checkbox"/> Psychiatric Illness (Depression, addiction, etc)</p> <p><input type="checkbox"/> Seizures/epilepsy</p> <p><input type="checkbox"/> SIDS (crib death)</p> <p><input type="checkbox"/> Stroke <u>before age 55</u></p> <p><input type="checkbox"/> Sudden Death <u>before age 50</u></p> <p><input type="checkbox"/> Other _____</p>	<p>Child's SURGERIES</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Appendectomy Age _____</p> <p><input type="checkbox"/> Adenoidectomy Age _____</p> <p><input type="checkbox"/> Ear Tubes Age _____</p> <p><input type="checkbox"/> Eye Surgery Age _____</p> <p><input type="checkbox"/> Hernia repair Age _____</p> <p><input type="checkbox"/> Tonsillectomy Age _____</p> <p><input type="checkbox"/> Other</p>																																																
<p>Social/Environmental</p> <p>Child lives w/:</p> <p><input type="checkbox"/> Parent(s):</p> <p style="margin-left: 20px;"><input type="checkbox"/> Together</p> <p style="margin-left: 20px;"><input type="checkbox"/> Mother</p> <p style="margin-left: 20px;"><input type="checkbox"/> Father</p> <p><input type="checkbox"/> Relative _____</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Adopted</p> <p><input type="checkbox"/> Smokers live in home with child?</p> <p><input type="checkbox"/> Substance Use</p> <p><input type="checkbox"/> Tobacco Use</p> <p><input type="checkbox"/> Child attends daycare</p> <p><input type="checkbox"/> Driving</p> <p><input type="checkbox"/> Pets in the home? _____</p> <p><input type="checkbox"/> Home built before 1960</p> <p><input type="checkbox"/> Well water</p> <p><input type="checkbox"/> Sexually Active</p> <p><input type="checkbox"/> Sibling Information _____</p> <p>Other _____</p> <p>_____</p>	<p>Current Medications:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																																																
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