Date Completed: ________________________________

Patient Name:_________________________ Date of Birth:____________ Gender:____________

Form Completed by:____________________________ Relationship:___________________

Pregnancy and Birth History	Social history
Hospital Born at: ________________________________	Who lives in patient's household? ______________________
Illness During Pregnancy: No Yes____________________	____
Medications During Pregnancy: No Yes _______________	What kind of Pets? _________________________________
Alcohol/Drug Abuse? No Yes _______________________	Water Source (Well, City of Dover, etc.)
Problems at Birth: No Yes__________________________	_______________
Birth Weight:____________	Primary Language spoken in home? ____________________
Gestation:_____________________	Smoke Exposure (including Secondary) Yes No
Received Hepatitis B Vaccine at Birth? No Yes, Date: ______	____
Passed Hearing Screen: Yes or No	

Does your child have any known drug allergies? ____

Family History	Patient Medical History
Has anyone in your Family suffered from the following?	Has your Child suffered from any of the following?

			Relation			
Allergies	Y	N		Allergies	Y	N
Asthma	Y	N		Asthma	Y	N
TB/Lung Disease	Y	N		Chicken Pox If Yes, What Year? ________	Y	N
HIV/AIDS	Y	N		Frequent Ear infections	Y	N
Suicide Attempts	Y	N		Vision/Hearing problems	Y	N
Heart Disease	Y	N		Skin Problems(eczema)	Y	N
High Blood Pressure	Y	N		TB/Lung Disease	Y	N
High Cholesterol	Y	N		Seizures	Y	N
Blood Disorder (Sickle Cell)	Y	N		High Blood Pressure	Y	N
Diabetes	Y	N		Heart Defects/Disease	Y	N
Seizure	Y	N		Liver Disease/Hepatitis	Y	N
Mental Illness	Y	N		Diabetes	Y	N
Cancer	Y	N		Kidney Disease	Y	N
Birth Defects	Y	N		Physical/Learning Disabilities	Y	N
Hearing Loss	Y	N		Bleeding Disorders/Hemophilia	Y	N
Speech Problems	Y	N		STD's	Y	N
Kidney Disease	Y	N		Emotional/Behavioral Problems	Y	N
Alcohol Abuse	Y	N		Depression/Suicidal Thoughts	Y	N
Hepatitis/Liver Disease	Y	N		Hospitalization/ Surgeries	Y	N
Thyroid Disease	Y	N		Physical/ Emotional/Sexual Abuse	Y	N
Learning Problems/ ADHD	Y	N		Bone or joint injuries	Y	N
Family Violence	Y	N		Obesity/ Eating Disorders	Y	N