



Name \_\_\_\_\_

**Birth History:**

Vaginal <input type="checkbox"/>		Cesarean <input type="checkbox"/>	
Term <input type="checkbox"/> Birth weight? Birth length?		Pre-term <input type="checkbox"/> How many weeks?	
Complications <input type="checkbox"/>			
Maternal medications used during pregnancy			

**Developmental History:**

	Age or Date
1. Crawling	
2. Walking	
3. Speech	
4. First tooth	
5. First tooth lost	
6. Pubertal changes	
Current Grade Level:	

**Major Illnesses:**

	Dates
1.	
2.	
3.	
4.	
5.	

**Major Surgeries:**

	Dates
1.	
2.	
3.	
4.	
5.	

**NAME** \_\_\_\_\_

**Family History of Medical Problems:**

Mother: Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

Father: Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

Siblings:

1. M F Age: \_\_\_\_\_ Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

2. M F Age: \_\_\_\_\_ Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

3. M F Age: \_\_\_\_\_ Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

4. M F Age: \_\_\_\_\_ Age of puberty: \_\_\_\_\_

Illnesses: \_\_\_\_\_

<b>History of Other Family Members:</b>	<i>Grandfather</i>		<i>Grandmother</i>		<i>Aunt</i>		<i>Uncle</i>	
	Paternal <input type="checkbox"/>	Maternal <input type="checkbox"/>	Paternal <input type="checkbox"/>	Maternal <input type="checkbox"/>	Paternal <input type="checkbox"/>	Maternal <input type="checkbox"/>	Paternal <input type="checkbox"/>	Maternal <input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short stature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tall stature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone/osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained death in children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME \_\_\_\_\_

**Review of System (check those that apply):**

**General:**

- Fever
- Chills
- Weakness
- Nervous
- Fatigue
- Sweats
- Heat Intolerance
- Cold Intolerance
- History of Anemia
- Changes in Weight
- Problems Sleeping

**Head:**

- Dizziness
- Headaches
- Pain
- Fainting
- History of Head Injury
- Stroke

**Ears:**

- Hearing Impairment
- Use Hearing Aid
- Pain
- Ringing in Ears

**Mouth & Throat:**

- Hoarseness
- Voice Changes

**Skin:**

- Rashes
- Itching
- Hives
- Easy Bruising
- Change in Hair

**Eyes:**

- Changes in Vision
- Double Vision
- Pain
- Pain when looking at light
- History of Glaucoma
- Cataracts
- Injuries

**Nose:**

- Nosebleeds
- Sinus Infections

**Urine:**

- Frequent Urination
- Pain When Voiding
- Slowing of Urinary System
- Blood in Urine
- Prostate Swelling or Pain
- Kidney Stones

If Diabetic complete the following:

Diagnosed as diabetic: \_\_\_\_\_ Last Eye Exam: date \_\_\_\_\_

Urine micro-albumin: date: \_\_\_\_\_

Previous Hgb A1C: date: \_\_\_\_\_ value: \_\_\_\_\_%

Type of Meter \_\_\_\_\_

Frequency of Blood Sugar testing \_\_\_\_\_

Blood Sugar ranges \_\_\_\_\_

Insulin Pump Type: \_\_\_\_\_

Date Insulin Pump started: \_\_\_\_\_

Basal Rates: \_\_\_\_\_

Insulin/Carb Ratio: \_\_\_\_\_

Correction Sliding Scale: \_\_\_\_\_