

Name: _____ Date: _____

Allergies to medicine: Y N If yes, what medicine: _____

Medications/dose: _____ Vitamin/type: _____ Fluoride _____

Any problems during pregnancy or delivery: Y N APGAR 1 min _____ 5 min _____

If yes explain: _____

Breast feed Y N How long? _____ Formula amount _____ type _____

Other Or Side Effects

Any significant family history? _____

Any sudden death in the family? Y N Who? _____

Is your home child proof? Y N

Does anyone at home smoke? Y N

Any guns at home? Y N Are they locked up? Y N

Do you use a car seat? Y N Seat belt? Y N

What are your hobbies? _____

Do you play sports? Y N type _____

Are you having any problems at school (grades, fighting, absences)? _____

Do you exercise? Y N Amount: _____

Watch TV hrs/day: _____

Computer hrs/day: _____

Read hrs/day: _____

Video games hrs/day: _____

Are you concerned about your weight? Y N

Ever seen by a psychiatrist/psychologist? Y N

Suicide attempt? Y N

Is your home smoke free? Y N

Do you smoke? Y N

use alcohol? Y N

use illegal drugs? Y N

Are you sexually active? Y N

safe sex? Y N

Any additional information? _____

IMMUNIZATIONS: Type/date received	
Polio	_____
Hepatitis B	_____
DTP	_____ DT: _____
Hib	_____ MMR _____
Chicken pox	_____ Disease/Yr _____
Pprevnar	_____

Please ask the front desk for a record release form to get your records from your previous physician.