Patient Information

Patient Name: _____ D.O.B: _____

Please list any past medical or surgical history? _____

Please list any medications patient takes regularly if any: _____

Please list any allergies the patient has if any: _____
EPI PEN? __YES __NO

The patient rides in a: ___rear facing care seat ____front facing care seat ___booster seat ___seatbelt

Does the patient wear a helmet when riding a bike?

Family History -Names NOT Required-

How many siblings does patient have? _____ Birth Order of patient (ie: 1st, 2nd, 3rd): _____

Please list medical conditions such as but not limited to cancer, diabetes, thyroid issues, depression

Mother: _____
Mother's Siblings: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Maternal Aunts: _____
Maternal Uncles: _____
Father: _____
Father's Siblings: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Paternal Aunts: _____
Paternal Uncles: _____

Environmental Demographics

Type of Residence: __Single Family __Multifamily __Condo __Town House __Apartment

Type of water source: ___Municipal __Well __ Bottled
Any lead concerns? ___YES ___NO
Are there any smokers living in the home? ___YES __NO
Does the residence have (CHECK ALL THAT APPLY):
___ Smoke Alarms
___Carbon Monoxide Detectors
___Pool
___Pets
___Guns

Education

Name of school:_____ Grade: _____
Avg Grades:_____

The patient performs __at __above __below grade level.
Does the patient have/need (CHECK ALL THAT APPLY): ___Special Needs ___Early Intervention ___ IEP