RUSH MEMORIAL HOSPITAL PROVIDER PRACTICES

Name: _____ MR #: _____

Date of Birth: _____ **Age**: _____ **Sex**: M or F

INITIAL HISTORY

HOUSEHOLD: Please list all of those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems
1.			
2.			
3.			
4.			
5.			

If there are siblings not living in the household, list their name(s), age(s), and where they live.

_____

_____

Who has custody of the child? _____

Does the child have a routine visitation with non-custodial parent(s)? ____Yes ____No How often? _____

Does anyone in the household smoke? ____Yes ____No

What is your preferred Pharmacy and where? _____

BIRTH HISTORY

Birth Weight: _____ Delivery: ____Vaginal _____Cesarean - If Cesarean, why?_____

Was the baby born at term?____ Early?____ Late?____ How many weeks? _____

Feedings: ____Breast ____Bottle

Did baby have any complications at birth? ____Yes ____No

Explain: _____

Did mother have any complications at birth? ____Yes ____No

Explain: _____

During pregnancy did mother: Smoke ____Yes ____No Drink Alcohol ____Yes ____No

Use drugs or medications ____Yes ____No What: _____ When: _____

GENERAL

Is your child in good health? ____Yes ____No Explain: _____

Does your child have any serious medical condition(s)? ____Yes ____No Explain: _____

Has your child had any serious injuries or accidents? ____Yes ____No Explain: _____

Has your child had any surgeries? ____Yes ____No Explain: _____

Has your child ever been hospitalized? ____Yes ____No Explain: _____

Does your child have any medication allergies? ____Yes ____No Explain: _____

Is your child's immunizations up to date? ____Yes ____No Explain: _____

DEVELOPMENT

Does your child have any physical developments? ____Yes ____No Explain: _____

Does your child have any attention span problems? ____Yes ____No Explain: _____

Does your child have any mental or emotional development(s)? ____Yes ____No Explain: _____

Is your child in school? ____Yes ____No Explain: _____

How is you his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

FAMILY HISTORY

Have any family members had the following:

Deafness	____Yes ____No	Who_____	Comments_____
Blindness	____Yes ____No	Who_____	Comments_____
Asthma	____Yes ____No	Who_____	Comments_____
Tuberculosis	____Yes ____No	Who_____	Comments_____
Heart Disease before 50 yrs old	____Yes ____No	Who_____	Comments_____
High blood pressure before 50	____Yes ____No	Who_____	Comments_____
High cholesterol	____Yes ____No	Who_____	Comments_____
Anemia	____Yes ____No	Who_____	Comments_____
Bleeding disorder	____Yes ____No	Who_____	Comments_____
Liver disease	____Yes ____No	Who_____	Comments_____
Kidney disease	____Yes ____No	Who_____	Comments_____
Diabetes before 50 years old	____Yes ____No	Who_____	Comments_____
Bed-wetting after 10 years old	____Yes ____No	Who_____	Comments_____
Epilepsy or seizures	____Yes ____No	Who_____	Comments_____
Alcohol abuse	____Yes ____No	Who_____	Comments_____
Drug abuse	____Yes ____No	Who_____	Comments_____
Mental Illness	____Yes ____No	Who_____	Comments_____
Immune problems, HIV, or AIDS	____Yes ____No	Who_____	Comments_____
Birth Defects	____Yes ____No	Who_____	Comments_____

Additional family history: _____

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox	____Yes ____No	When: _____
Frequent ear infections	____Yes ____No	Explain: _____
Problems hearing	____Yes ____No	Explain: _____
Seasonal allergies	____Yes ____No	Explain: _____
Problems with eyes or vision	____Yes ____No	Explain: _____
Asthma, bronchitis or pneumonia	____Yes ____No	Explain: _____
Any heart problems or heart murmur	____Yes ____No	Explain: _____
Anemia or bleeding problems	____Yes ____No	Explain: _____
Blood transfusion(s)	____Yes ____No	Explain: _____
Frequent abdominal pain	____Yes ____No	Explain: _____
Constipation requiring doctor visits	____Yes ____No	Explain: _____
Bladder or kidney infection	____Yes ____No	Explain: _____
Bed-wetting after 5 years old	____Yes ____No	Explain: _____
Girls – Has she started her menstrual periods	____Yes ____No	When: _____
Girls – Are there problems with her periods	____Yes ____No	Explain: _____
Any skin problems	____Yes ____No	Explain: _____
Frequent headaches	____Yes ____No	Explain: _____
Seizures or other neurological problems	____Yes ____No	Explain: _____
Diabetes	____Yes ____No	Explain: _____
ADHD/Bipolar	____Yes ____No	Explain: _____
Thyroid or other endocrine problems	____Yes ____No	Explain: _____
Use of alcohol, drugs, or tobacco	____Yes ____No	When: _____
Any other significant problem(s)	____Yes ____No	Explain: _____

Form Completed By: _____ Date Completed: _____