

Birth history (weight, length, full-term, complications): _____

Health Conditions: _____

Developmental or learning issues: _____

Previous surgeries or hospitalizations: _____

Medications, include vitamins, etc: _____

Allergies to medication, food, etc: _____

<u>Review of systems</u>	<u>Yes</u>	<u>No</u>	<u>Family history</u>	<u>Yes</u>	<u>No</u>	<u>Relationship</u>
Abnormal weight change			Skin cancer			
Recent fever			Melanoma			
Vision changes			Eczema			
Ear/nose/throat issues			Asthma			
Swollen glands			Environmental allergies			
Recurrent infections			Autoimmune disorders			
Breathing problems			Bleeding problems			
Heart problems			Anesthesia problems			
Bleeding problems			Scarring acne			
Vomiting/diarrhea			<u>Social history</u>	<u>Yes</u>	<u>No</u>	<u>Explanation</u>
Constipation			Vaccines up to date			
Muscle aches/weakness			Pets			
Swollen joints			Alcohol use			
Kidney/bladder issues			Tobacco use			
Irregular periods			Illicit drug use			
Headaches			Sexually active			
Depression/anxiety						
Difficulty sleeping						

Person completing form and relationship to patient: _____

Physician signature and date reviewed: _____