ALL ABOUT KIDS PEDIATRICS, LLC.

292 BROOKS MALOTT ROAD

MOUNT ORAB, OHIO 45154

PHONE: 937-444-0035 FAX: 937-444-0036

CHILD'S LEGAL NAME: ______________________________________ **BIRTHDATE:** _____________________________

BIRTH HISTORY:

WAS THE CHILD BORN WITHIN 3 WEEKS OF DUE DATE? YES NO WAS THE CHILD BORN: VAGINAL OR C-SECTION

BIRTH WEIGHT: ____________ BIRTH LENGTH: ___________ ANY COMPLICATIONS DURING PREGNANCY/DELIVERY? YES NO

IF THERE WERE COMPLICATIONS, PLEASE EXPLAIN: ____

AT WHAT HOSPITAL WAS THE CHILD BORN: ________________________________ CITY: _______________________________

PREVIOUS SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS ILLNESSES:

DESCRIPTION	WHEN	WHERE

SOCIAL HISTORY:

DOES THE PATIENT CURRENTLY LIVE IN A/AN (PLEASE CIRCLE ONE OF THE FOLLOWING):

SINGLE FAMILY HOME APARTMENT CONDOMINIUM MOBILE HOME PUBLIC HOUSING

WHO DOES THE CHILD CURRENTLY LIVE WITH? ____

ARE THERE PETS IN THE HOME? YES NO IF SO, WHAT TYPE OF PET/S? ____

IS THE CHILD EXPOSED TO LEAD BASED PAINT? YES NO WAS THE CHILD'S HOME BUILT PRIOR TO 1978? YES NO

IS YOUR HOUSE SUPPLIED BY WELL WATER? YES NO DOES THE CHILD LIVE NEAR ANY FACTORIES OR PLANTS? YES NO

IS THE CHILD EXPOSED TO SECONDHAND SMOKE? YES NO

ARE ANY MEMBERS OF THE CHILD'S HOUSEHOLD EXPOSED TO ANY CHEMICALS AT WORK? ______________________________

WHO DOES THE CHILD RELY ON FOR SOCIAL SUPPORT? ____

ARE THERE ANY GUNS IN THE HOUSEHOLD? YES NO IF SO, ARE THEY LOCKED UP? YES NO

FAMILY MEDICAL HISTORY:

PLEASE NOTE IF ANY OF THE CHILD'S FAMILY MEMBERS (PARENTS, SISTERS, BROTHERS, AUNTS, UNCLES, GRANDPARENTS) HAVE ANY OF THE FOLLOWING. PLEASE NOTE IF IT IS A MATERNAL OR PATERNAL RELATIVE AS WELL.

TUBERCULOSIS (TB) _______________________________

HEPATITIS _______________________________________

HIV/AIDS ____

ALCOHOLISM _____________________________________

HIGH BLOOD PRESSURE _____________________________

HEART DISEASE/HEART ATTACK ______________________

STROKE ____

DIABETES ____

CANCER (TYPE) ___________________________________

ANEMIA ____

BLEEDING PROBLEMS_______________________________

MIGRAINE HEADACHES _____________________________

EPILEPSY (SEIZURES) ______________________________

DRUG USE _______________________________________

MENTAL ILLNESS/DEPRESSION ______________________

LUNG DISEASE ___________________________________

ALLERGIES/ASTHMA _______________________________

HEARING PROBLEMS _______________________________

VISION PROBLEMS ________________________________

INHERITED GENETIC DISEASE ______________________

FEMALES 12 AND ABOVE, PLEASE SEE OTHER SIDE OF FORM

FOR FEMALES, AGES 12 AND ABOVE

AGE WHEN PERIOD STARTED _____________ DATE OF LAST PERIOD _____________ DATE OF LAST PAP SMEAR _____________

PERIODS ARE CONSIDERED (PLEASE CIRCLE ONE): REGULAR IRREGULAR ABSENT

ANY CRAMPING WITH PERIODS (PLEASE CIRCLE ONE): NONE MILD SEVERE

MENSTRUAL FLOW IS (PLEASE CIRCLE ONE): NORMAL LIGHT HEAVY ABSENT

HISTORY OF ABNORMAL PAP SMEAR? YES NO HISTORY OF BREAST LUMP? YES NO

IS CHILD SEXUALLY ACTIVE? UNKNOWN YES NO IF YES, DOES CHILD USE CONTRACEPTION? YES NO

IF USING CONTRACEPTION, WHAT FORM? ____

NUMBER OF PREGNANCIES? _______ MISCARRIAGES ________ ABORTIONS _______ STILLBORNS ________TWINS ________

BREAST CANCER HISTORY IN ANY OF THE FOLLOWING (PLEASE CIRCLE ANY THAT APPLY):

SELF MOTHER SISTER GRANDMOTHER AUNT