CHILD & TEEN
Wellness Center

Daniel J. Levy, M.D., FAAP
Adriane Hanelt, CPNP
Carrie Collins, CPNP

**Patient Name**: _____ **Date of Birth**: _____ **Sex**: *male* *female*

Form completed by: _____ Relationship to patient: _____

## Pregnancy and Birth History

Name of Hospital: _____
Illness during pregnancy? No ☐ Yes ☐
Any medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of Delivery? Vaginal C-Section
Birth Weight_____ Discharge weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hep B vaccine: _____
Newborn Hearing Screen No ☐ Yes ☐

## Psychosocial History

Who lives in household? _____
How many? _____
Who cares for child?
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____ Dates: _____
Other Languages? _____
_____

## Family History

Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers) had:

| | | **Who?** |
|---|---|---|
| **Allergies (List) _____** | | |
| **Asthma** | **No ☐ Yes ☐** | _____ |
| **TB/Lung Disease** | **No ☐ Yes ☐** | _____ |
| **HIV/AIDS** | **No ☐ Yes ☐** | _____ |
| **Suicide Attempts** | **No ☐ Yes ☐** | _____ |
| **Heart Disease** | **No ☐ Yes ☐** | _____ |
| **High Blood Pressure/Stroke** | **No ☐ Yes ☐** | _____ |
| **High Cholesterol** | **No ☐ Yes ☐** | _____ |
| **Blood Disorders/Sickle Cell** | **No ☐ Yes ☐** | _____ |
| **Diabetes** | **No ☐ Yes ☐** | _____ |
| **Seizures** | **No ☐ Yes ☐** | _____ |
| **Mental Illness** | **No ☐ Yes ☐** | _____ |
| **Cancer** | **No ☐ Yes ☐** | _____ |
| **Birth Defects** | **No ☐ Yes ☐** | _____ |
| **Hearing Loss** | **No ☐ Yes ☐** | _____ |
| **Speech Problems** | **No ☐ Yes ☐** | _____ |
| **Kidney Disease** | **No ☐ Yes ☐** | _____ |
| **Alcohol/Drug Abuse** | **No ☐ Yes ☐** | _____ |
| **Hepatitis/Liver Disease** | **No ☐ Yes ☐** | _____ |
| **Thyroid Disease** | **No ☐ Yes ☐** | _____ |
| **Learning Problems/Attention** | **No ☐ Yes ☐** | _____ |
| **Deficit Disorder** | **No ☐ Yes ☐** | _____ |
| **Family Violence** | **No ☐ Yes ☐** | _____ |

**Other:** _____

## Medical History

**Has your child ever had**:

Allergies (List) _____
_____

| | |
|---|---|
| Asthma | No ☐ Yes ☐ |
| Chicken Pox (Year) | No ☐ Yes ☐ |
| Frequent Ear Infections | No ☐ Yes ☐ |
| Vision/Hearing Problems | No ☐ Yes ☐ |
| Skin Problems/Eczema | No ☐ Yes ☐ |
| TB/Lung Disease | No ☐ Yes ☐ |
| Seizures/Epilepsy | No ☐ Yes ☐ |
| High Blood Pressure | No ☐ Yes ☐ |
| Heart Defects/Disease | No ☐ Yes ☐ |
| Liver Disease/Hepatitis | No ☐ Yes ☐ |
| Diabetes | No ☐ Yes ☐ |
| Kidney Disease/Bladder Infections | No ☐ Yes ☐ |
| Physical or Learning Disabilities | No ☐ Yes ☐ |
| Bleeding Disorders/Hemophilia | No ☐ Yes ☐ |
| Sexually Transmitted Diseases | No ☐ Yes ☐ |
| Emotional or Behavioral Problems | No ☐ Yes ☐ |
| Depression/Suicidal Thoughts | No ☐ Yes ☐ |
| Hospitalizations/Surgeries | No ☐ Yes ☐ |
| Physical/Emotional/ Sexual Abuse | No ☐ Yes ☐ |
| Bone or Joint Injuries | No ☐ Yes ☐ |
| Obesity/Eating Disorders | No ☐ Yes ☐ |

Other: _____
Current Medications: _____
_____