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2800 Blue Ridge Road, Suite 405
Raleigh, North Carolina 27607
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Patient / Family History -Initial Visit

Please complete the following and bring to your appointment. Thank you.

Patient: _____ DOB: _____

Reason for visit: _____

When did the problem begin? _____

Allergies: (medicines, foods, Latex, etc.) _____

Current medications & dose: _____

Current herbal medicines (ginseng, caffeine, etc.), nutritional supplements (multivitamins, Gatorade, etc.) or complementary therapies (chiropractic, massage, hypnosis, etc.): _____

Birth history: Full-term _____ Premature _____ (# of weeks premature _____) Birth weight: _____

Complications with pregnancy/delivery? _____

Patient's Medical History: (please check if your child/adolescent has been diagnosed with the following:)

	YES	NO		YES	NO
ADD	_____	_____	Hearing impairment	_____	_____
ADHD	_____	_____	Heart problems	_____	_____
Allergies (environmental)	_____	_____	Hypertension	_____	_____
Anemia	_____	_____	Immune problems	_____	_____
Asthma	_____	_____	Migraine headaches	_____	_____
Arthritis	_____	_____	Muscle problems	_____	_____
Autism	_____	_____	Seizure disorder	_____	_____
Bleeding Disorders	_____	_____	Sickle Cell disease	_____	_____
Cancer	_____	_____	Sickle Cell trait	_____	_____
Cerebral Palsy	_____	_____	Speech problems	_____	_____
Constipation	_____	_____	Spina Bifida	_____	_____
Developmental delay	_____	_____	Stomach reflux	_____	_____
Diabetes	_____	_____	Thyroid problems	_____	_____
Down syndrome	_____	_____	Tracheomalacia	_____	_____

Any other specific medical history of patient? _____

Hospitalizations? (Dates and Reasons) _____

Please complete other side

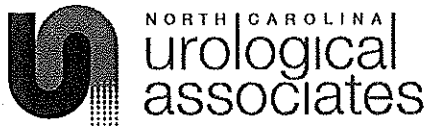
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Previous Surgeries? _____

Family Medical History: Please check if there is a family history of the following - include natural parents, siblings, aunts, uncles and grandparents only:

	YES	NO		YES	NO
Anemia	_____	_____	Down syndrome	_____	_____
Anesthesia problems	_____	_____	Gastrointestinal problems	_____	_____
Asthma	_____	_____	Heart problems	_____	_____
Arthritis	_____	_____	Hypertension	_____	_____
Cancer	_____	_____	HIV / Aids	_____	_____
Cerebral Palsy	_____	_____	Liver problems	_____	_____
Cholesterol problems	_____	_____	Respiratory problems	_____	_____
Cystic fibrosis	_____	_____	Sickle cell disease	_____	_____
Birth defects	_____	_____	Sickle cell trait	_____	_____
Bleeding disorders	_____	_____	Spina Bifida	_____	_____
Diabetes	_____	_____	Thyroid problems	_____	_____
Kidney Stones	_____	_____	Kidney Disease	_____	_____

List patient's siblings and their ages: _____

Social History (please check where appropriate): Patient's grade in school: _____

Parents are married _____, divorced _____, separated _____

Patient lives with natural parents _____, guardian _____, grandparents _____, adoptive parents _____, foster care _____

Completed by: _____ Date: _____

Relationship to patient: _____

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