**ALL STAR PEDIATRICS, PC**
**6428 JOLIET ROAD, SUITE 201**
**COUNTRYSIDE, IL 60525**

Child's Name: _____ Date of Birth: _____

**Household- Social History:**
Parents Marital Status: Single Married Widowed Divorced Separated
Any Former Marriages: Father- Yes / No Mother - Yes / No

Please list all those living in the child' home:

| Name: | Relationship to Child | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Are there siblings or half siblings or step siblings not listed? If so please list their names and ages and where they live:
_____
_____
_____
_____

Have any of your children died: _____
If mother and father are not living together or if child does not live with parents, what is the child's custody status?_____
If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home:_____

Do you have any pets at home? Yes/No If No Explain:_____
Are there any smokers in the home? Yes/No, If Yes Explain:_____
Are there any guns in the home? Unarmed, Locked? Yes/No Explain_____

**Birth History:**
Birth Place: _____ Birth Weight: _____ Apgar Score: _____
Please circle any that apply: natural conception, IVF, egg donor, sperm donor, adopted, Other_____
Please circle: Was the delivery Vaginal or Cesarean? If cesarean, why? _____
Please circle: Was the baby born Full Term? Or early? If early how many weeks' gestation? _____
Did your baby have any problems right after birth: Yes/No Explain:_____
Please circle: Did you breastfeed or bottle feed?
Did your baby go home with mother from the Hospital? Yes/No Explain:_____
During pregnancy, did mother Smoke? Yes/No Drink Alcohol? Yes/No
During pregnancy, did mother use drugs or medications? Yes/No – What/When: _____

**General:**
Are your child's immunizations up to date? Yes/No, Explain:_____
Are you concerned about your child's health? Yes/No, Explain:_____
Is your child allergic to any medicines or drugs? Yes/No, Explain:_____
In times of stress, do you have support available? Yes/No, Explain:_____

**Development:**
Have there been any developmental delays?
Physical? _____ Speech? _____ Fine motor? _____
Are you concerned about your child's mental or emotional development? Yes/No Explain_____

**Past Medical History:**

Does your child have or has he/she ever had?

| | |
|---|---|
| Serious injuries or accident | Yes/No Explain_____ |
| Surgeries (date, type) | Yes/No Explain_____ |
| Hospitalizations (date, reason) | Yes/No Explain_____ |
| Chickenpox | Yes/No Explain_____ |
| Frequent ear or sinus infections | Yes/No Explain_____ |
| Frequent pharyngitis/tonsillitis | Yes/No Explain_____ |
| Other infectious diseases | Yes/No Explain_____ |
| Allergic Rhinitis: | Yes/No Explain_____ |
| Allergies to Animals: | Yes/No Explain_____ |
| Outdoor allergens: | Yes/No Explain_____ |
| Indoor allergens: | Yes/No Explain_____ |
| Lung problems (wheezing, asthma, pneumonia) | Yes/No Explain_____ |
| Heart problems (murmur) | Yes/No Explain_____ |
| Frequent abdominal pain | Yes/No Explain_____ |
| Constipation requiring doctor visit | Yes/No Explain_____ |
| Reflux | Yes/No Explain_____ |
| Urinary tract infection | Yes/No Explain_____ |
| Bedwetting (after 6 yr. old) | Yes/No Explain_____ |
| Eye conditions/corrective lenses | Yes/No Explain_____ |
| Problems with ears/hearing | Yes/No Explain_____ |
| Any chronic skin problems (acne/eczema) | Yes/No Explain_____ |
| Anemia or bleeding problems: | Yes/No Explain_____ |
| Blood transfusions | Yes/No Explain_____ |
| Frequent headaches: | Yes/No Explain_____ |
| Convulsions/Seizures | Yes/No Explain_____ |
| ADHD/ADD | Yes/No Explain_____ |
| Mental Health | Yes/No Explain_____ |
| Orthopedic problems | Yes/No Explain_____ |
| Diabetes | Yes/No Explain_____ |
| Endocrine problems | Yes/No Explain_____ |
| (Girls)Are there problems with her period | Yes/No Explain_____ |
| (Girls)Has she started her menstrual period | Yes/No Explain_____ |
| Use of alcohol or drugs | Yes/No Explain_____ |
| Emotional problems | Yes/No Explain_____ |

Any other comments:_____