REDWOOD PEDIATRICS
An Affiliate of Children's Mercy

Patient Name: _____ M / F Date of Birth: _____

Parent Names: _____ Number of Siblings: _____

Sisters ____ Brothers____

Active or Chronic Problems (check all that apply for this patient or list below):

☐ ADHD	☐ Deafness	☐ Diabetes	☐ Heart Disease	☐ Urinary Reflux
☐ Allergies	☐ Depression	☐ Ear Infections$_{(frequent)}$	☐ Mental illness	☐ Frequent or Recurrent UTI
☐ Anxiety	☐ Developmental Delay	☐ Eczema	☐ Migraines	☐ Seizures
☐ Asthma	☐ DDH – hip dysplasia	☐ Elevated Cholesterol	☐ Obesity	☐ Sickle Cell
☐ Cancer		☐ Headaches	☐ Scoliosis	☐ Other (write below)

Please list other active or chronic problems: _____
Other doctors and/or specialists your child sees: _____
Patient's Drug/food Allergies & Reaction: _____

Current Medications – Please list all over the counter medications, supplements, herbal medications your child takes:

Medication	Dosage	Times per Day	Prescribed by

Family History

☐ Adopted

Please circle any of the following conditions that are present in 1st degree relatives (siblings, parents):

Heart Problems under the age of 20 Thyroid Problems Asthma

Cholesterol Problems Eczema Nasal Allergies

Social History

Father's Occupation: _____ ☐ Full Time ☐ Part time ☐ School

Mother's Occupation: _____ ☐ Full Time ☐ Part time ☐ School

Parent's Relationship: ☐ Married ☐ Living Together ☐ Single Parent ☐ Guardian ☐ Foster Parent ☐ Same Sex Parents ☐ Separated ☐ Divorced

Smokers in home: Y N Pets/animals in home and type: _____

Surgical History

Has your child had any of the following operations? If yes, fill in the year of surgery.

	Year	Admitted (Y/N)	Reason
Ear Tubes Placed			
Tonsils/Adenoids Removed			

Other operations/procedures: _____