# *Welcome to Davidson Clinic!*

Please complete the following information for your child.  This will help us get to know you and your child better.
*Thank you, and we look forward to serving you!*


Patient's Name: _____ Date of Birth: _____

Who does your child live with? _____

Name of Daycare and/or School?  Grade? _____

Are there any pets in the household?          Yes    No    If so, how many and what type? _____

What does your child like to do for fun? _____

Is your child exposed to tobacco products?          Yes    No    If so, what type? _____ If so, how much? _____

***If your child has had any immunizations prior to coming to our clinic, please provide us a copy of the Immunization Record***

## Present Medical History

| *List any Chronic/On-going Medical Problems* | *List any allergies and the reaction* | *Medication Name* <br> *(also bring the medication bottles)* | *Strength* | *How often do you take?* <br> *Notes/Description* |
|---|---|---|---|---|
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## Past Hospitalizations, Surgeries, Serious Injuries
## (including blood transfusions)

_____

_____

_____

_____

_____

_____

## Anything else?

_____

_____

_____

_____

_____

# Family History

| | Self | Mother | Father | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather | Brother | Sister |
|---|---|---|---|---|---|---|---|---|---|
| ADHD | | | | | | | | | |
| Alcohol/Drug Abuse | | | | | | | | | |
| Allergies | | | | | | | | | |
| Anemia | | | | | | | | | |
| Arthritis | | | | | | | | | |
| Asthma | | | | | | | | | |
| Bleeding Disorder | | | | | | | | | |
| Blood Disorder (specify) | | | | | | | | | |
| Bronchitis | | | | | | | | | |
| Cancer (specify) | | | | | | | | | |
| Celiac Disease | | | | | | | | | |
| Depression | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Emphysema | | | | | | | | | |
| Gallbladder Disorder | | | | | | | | | |
| Gout | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| HIV | | | | | | | | | |
| Kidney Disorder (including stones) | | | | | | | | | |
| Liver Disease | | | | | | | | | |
| Lung Disease (specify) | | | | | | | | | |
| Mental Illness (specify) | | | | | | | | | |
| Rheumatic Fever | | | | | | | | | |
| Skin Disorder | | | | | | | | | |
| STD (specify) | | | | | | | | | |
| Stomach/Intestinal Disorder | | | | | | | | | |
| Stroke | | | | | | | | | |
| Suicide | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | |
| Tuberculosis | | | | | | | | | |
| Other (specify) | | | | | | | | | |

*Maternal* : related through the mother's side of the family

*Paternal* : related through the father's side of the family