tcc | The Children's Clinic
WELCOMING FAMILIES SINCE 1911

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Patient Name ____________ Nickname ____________ Date of Birth ____________
Parent Name ____________ Date of Birth ____________ Occupation ____________
Parent Name ____________ Date of Birth ____________ Occupation ____________
Marital Status of Family? ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Other ____________
If divorced: Who has custody? ____________ Visitation Rights? ____________
Any other people living in the home? ____________
Are there any smokers in the home? ❑ Yes ❑ No If yes, who? ____________
Are there any pets in the home? ❑ Yes ❑ No If yes, what kind? ____________

Patient's Siblings:
Name ____________ Date of Birth ____________
Name ____________ Date of Birth ____________
Name ____________ Date of Birth ____________
Name ____________ Date of Birth ____________

Past Medical History of Patient:
Any Complications or Problems at Birth: ❑ Yes ❑ No ____________
Hospitalizations/Surgeries (Include Reason and Date/Age): ____________
____
Serious Injuries/Accidents (Include Type and Date/Age): ____________
____
Blood Transfusion(s): ❑ Yes ❑ No (Reason/Date or Age) ____________
Previous Doctor/Clinic: ____________ Have you requested records: ❑ Yes ❑ No
Do you have a copy of the Immunization Record: ❑ Yes ❑ No Chickenpox Disease: ❑ Yes ❑ No Date/Age: ____________
Allergies: (Medications/Environmental/Foods) ____________

❑ 3 or more ear infections
❑ 3 or more throat infections
❑ Asthma/Wheezing
❑ Constipation
❑ Eczema
❑ Headaches
❑ Kidney/Bladder Infections
❑ Seizures
❑ Sinus Problems
❑ Stomachaches
❑ Eye Problems
❑ Hearing Problems
❑ Learning Disabilities
❑ School Problems
❑ ADD/ADHD
❑ Mental/Emotional Problems
❑ Autism Spectrum Disorder
❑ Developmental Delay
❑ Other: ____________
____
____

Family History: List Blood relatives with this health history: (M) Mother (F) Father (S) Sister (B) Brother (MGM) Mother's Mother (MGF) Mother's Father (PGM) Father's Mother (PGF) Father's Father (A) Aunt (U) Uncle (C) Cousin

_______ ADD/ADHD
_______ Alcoholism
_______ Allergies
_______ Anesthetic Complications
_______ Arthritis
_______ Asthma
_______ Anxiety
_______ Autoimmune Disease
_______ Blindness
_______ Blood Disorder
_______ Cancer – Breast
_______ Cancer – Cervical
_______ Cancer – Colon
_______ Cancer – Lung
_______ Cancer – Ovarian
_______ Cancer – Melanoma (Skin)
_______ Cancer – Uterine
_______ Cancer – Other
_______ Celiac Disease
_______ Coronary Heart Disease
_______ Crohns
_______ Cystic Fibrosis
_______ Deafness
_______ Depression
_______ Developmental Delay
_______ Diabetes
_______ Drug Dependency
_______ GERD (Reflux)
_______ Growth Development Disorder
_______ Heart Disease
_______ High Cholesterol
_______ Hypertension (High Blood Pressure)
_______ IBS (Irritable Bowel)
_______ Kidney Disease
_______ Learning Disabilities
_______ Migraines
_______ Muscular Disease
_______ Neurologic Disorder
_______ Other Gastrointestinal Disease
_______ Other Mental Illness
_______ Psychiatric Care
_______ Seizures
_______ Stroke
_______ Thyroid Disorder
_______ Tuberculosis
_______ Ulcerative Colitis
_______ Weight Disorder
_______ Other: (List Relative and Diagnosis)
____
____
____
____

Patients Greater than One Month Old