For Children ONLY!

Patient Name:_____ Date of Birth: _____ Age:

**Birth History**
Full Term | Premature [Yes|No] If yes, how many weeks Premature?
Did your child ever stay in the NICU? [Yes|No] If yes, how long?
Has your child ever required a breathing tube? [Yes|No] If yes, how long?

**Social History**
Mother's Name:
Father's Name:
Who is the Child's legal Parent | Guardian (able to make medical decisions) if it is not the parents listed above?
Do you have a Power of Attorney? [Yes|No]

Child lives with whom?
Mother and Father [Yes|No]
Mother [Yes|No]
Father [Yes|No]

Is the Child:
Exposed to cigarettes? [Yes|No]
Up to date on shots? [Yes|No]
In daycare or school? [Yes|No]
Passed a newborn hearing screen? [Yes|No]
Other:

Parent/Guardian Signature Print Name Date