TRESTLEWOOD PEDIATRICS
5082 Lovers Lane * Portage, MI 49002 * (616) 381-0118

Child's Name________________________ Birth date_____________________________
Address____________________________ Gender M F
City/State/Zip_______________________ Ethnicity______________________________
Phone_____________________________ Today's date___________________________

	Name	**Address/phone**	**Occupation/employer**
Father	____________________	____________________________	________________________
Mother	____________________	____________________________	________________________
Guardian	____________________	____________________________	________________________

Source of referral________________ Friends/relatives who come to this practice___________________
Previous physician_______________When/from where did you move?___________________________

Child's Medical History
(Please also provide a copy of your child's immunization record.)

Allergies_______________________ Medications____

Length of pregnancy in weeks ______ Pregnancy/delivery complications_____________________
Type of delivery: vaginal caesarean Apgar scores/birth condition________________________
Birth weight___________________ Infant diet: breast bottle How long?_______________

Hospitalizations, Surgeries, Trauma, Injuries (use the back of this page if more room is required):

Date	Type/Reason
______	____
______	____

Recurrent problems
Otitis media________
Tonsillitis__________
UTI________________
Constipation________
Bedwetting_________
Other______________
____
____

Chronic conditions
Asthma_____________
Eczema_____________
Diabetes____________
Seizures____________
Congenital
Heart Disease_______
Other______________
____

Childhood Infections
Chicken Pox______________
Rheumatic Fever___________
RSV_____________________
Rotavirus________________
Pertussis________________
Mono____________________
HIV_____________________
Hepatitis________________
Meningitis_______________
Measles/Mumps/Rubella____
UTI_____________________
Pneumonia_______________
Other____________________
____
____
____

Developmental/Behavioral/Psychiatric Conditions
Learning
Problems___________
Autism_____________
Speech Delay_______
Eating Disorder_____
____

ADD/ADHD_______
Depression_________
Oppositional
Defiant Disorder_____
Other______________
____

Child's Environmental/Social History

Child lives with: (include siblings)	Name	Relationship	Age
	____________________	____________________	_______
	____________________	____________________	_______
	____________________	____________________	_______
	____________________	____________________	_______

Parents' relationship: Married Unmarried Separated Divorced Widowed
Other living arrangements: ____

Check all that apply:

______Older home/lead or peeling paint
______Parental tobacco use
______Pets
______Pool/water near home
______Trampoline
______Infant walker with wheels
______Exposure to TB
______Fluoridated water
______Bike Helmet
______Car seat/Booster seat
______Ipecac available
______No aspirin use
______Working smoke detectors
______Hot water temp < 120F

Daycare (group/private/#days per week)____
School/grade/academic achievement____
Sports/activities____
Is this child adopted? Yes No Foreign or domestic adoption?______________________

Child's Family History

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Blood disorder (anemia, sickle cell, hemophilia, bleeding, etc)						
Lung condition (asthma, CF, etc.)						
Cardiac problem (heart attack, arrhythmia, cholesterol, etc.)						
Gastrointestinal problem (reflux, ulcers, Crohns, colitis, etc.)						
Neurological problem (seizures, MS, autism, etc.)						
Psychiatric disorder						
Vision or Hearing loss						
Birth defect						
Child or young adult death						
Diabetes						
Thyroid disease						
Behavioral or Learning problem						
Substance Abuse problem						
Liver disease						
Kidney Disease						
Cancer						
Skin condition						

Please provide more detail regarding any conditions noted above. Also include any other familial conditions not listed.____
____