Cayuga Family Medicine Initial Information Form for Children (June 2017) Today's Date _____

Name_____DOB:_____Age_____ Male__ Female__ Transgender____Other_____

Mother's full name and occupation _____

Partner's full name and occupation _____

May we leave messages regarding lab and Xray results on your answering machine? Yes____ No_____

What would you like to discuss today? Is your child having any symptoms or problems or need any specific tests?

_____

_____

_____

___

Past Medical History - Please list any hospitalizations or surgeries your child has had in the past,

_____

_____

_____

Please list all medications and dosing, herbs, vitamins, and supplements your child is taking more often than once a week.

_____

Has your child had any allergies or reactions to any medications? No___ Yes____

If yes, list the medicine and reaction. _____

If applicable, is your child up to date on vaccines? Yes __ No __

If no, please explain your thinking about vaccines _____

Please list previous medical office your child has been a patient of:

_____

Family History - For the following illnesses, please check if your child or one of the listed family members has had the disease. Please put the age of the earliest diagnosis (for example –father had his first heart attack in his late 50s).

Illness	Self	Father	Mother	Brother	Sister	Son	Daughter	Grandmother	Grandfather	Aunt	Uncle
High Blood Pressure	___	____	____	_____	____	___	____	_____	_____	____	____
High cholesterol	___	____	____	_____	____	___	____	_____	_____	____	____
Angina/Heart Attack	___	____	____	_____	____	___	____	_____	_____	____	____
Diabetes	___	____	____	_____	____	___	____	_____	_____	____	____
Breast Cancer	___	____	____	_____	____	___	____	_____	_____	____	____
Prostate Cancer	___	____	____	_____	____	___	____	_____	_____	____	____
Colon Cancer	___	____	____	_____	____	___	____	_____	_____	____	____
Other cancer _____	___	____	____	_____	____	___	____	_____	_____	____	____
Alcoholism	___	____	____	_____	____	___	____	_____	_____	____	____
Depression	___	____	____	_____	____	___	____	_____	_____	____	____
Other Mental Illness	___	____	____	_____	____	___	____	_____	_____	____	____
Asthma, Allergies, Ecsema	___	____	____	_____	____	___	____	_____	_____	____	____
Blood clots/phlebitis	___	____	____	_____	____	___	____	_____	_____	____	____
Thyroid problems	___	____	____	_____	____	___	____	_____	_____	____	____
Osteoporosis	___	____	____	_____	____	___	____	_____	_____	____	____
Childhood hip problems	___	____	____	_____	____	___	____	_____	_____	____	____
Other	___	____	____	_____	____	___	____	_____	_____	____	____

Social History –

Who else lives at home? (Siblings, relatives, nannies) _____

Does anyone smoke? _____ If yes, do they smoke inside or outside the house or both? _____

Are there any pets in the house? ____ If yes, what kind? _____

Do you have any concerns about how your child is eating? _____

Do you have any concerns about how your child is sleeping? _____
What kinds of exercise does your child do? _____ How much and how often? _____