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### First Visit Form for Children

*We look forward to your child's first visit in our office!* Please find a quiet moment to complete this form to bring to your appointment. We have carefully chosen these questions to address all aspects of your child's health. Your answers will help us to work with you in a way that best meets your family's health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so during your appointment.

**Today's Date:** \_\_\_\_\_

**Child's First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Date of Birth** \_\_\_/\_\_\_/\_\_\_

**Phone Number** Home (\_\_\_\_) \_\_\_\_\_ Parent's Work (\_\_\_\_) \_\_\_\_\_  
Parent's Cell or Pager (\_\_\_\_) \_\_\_\_\_

Where can we leave a confidential message? (circle one) Home Work Cell

**Parent's Email Address** \_\_\_\_\_

**Mailing Address** \_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact** Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone Number Home (\_\_\_\_) \_\_\_\_\_, Work (\_\_\_\_) \_\_\_\_\_

**Ethnicity:** (circle one) Latino Asian/Pacific Islander Black White Native American  
Other \_\_\_\_\_

**Person completing this form:** \_\_\_\_\_

Relationship to child \_\_\_\_\_

**Who referred you to Dr. Miller or Dr. Swan?** \_\_\_\_\_

Please describe the **major expectations** that you have of your family doctor:

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**Birth Information**

Age of mother at delivery \_\_\_\_\_

Was child born **prematurely**? (circle one) YES NO

If yes, how many weeks early? \_\_\_\_\_

Were there any problems with the **pregnancy**? (circle one) YES NO

If yes, please explain \_\_\_\_\_

Was the **delivery** Vaginal or Cesarian Section? \_\_\_\_\_

Please describe any **problems with the delivery** \_\_\_\_\_

**Developmental Milestones**

At what age (in months) did your child:

Sit alone \_\_\_\_\_

Walk alone \_\_\_\_\_

Speak her/his first words \_\_\_\_\_

Pee in the potty \_\_\_\_\_

Speak her/his first sentence \_\_\_\_\_

Poop in the potty \_\_\_\_\_

Do you have any concerns about your child's physical development?

(circle one) YES NO

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the names of any **medical providers, dentists and complementary medicine providers** who have treated your child in the recent past:

| Name | Telephone #<br>(optional) | Profession/Specialty | Dates of treatment |    |
|------|---------------------------|----------------------|--------------------|----|
|      |                           |                      | From               | To |
|      |                           |                      |                    |    |
|      |                           |                      |                    |    |
|      |                           |                      |                    |    |
|      |                           |                      |                    |    |

Please list the names of any **psychiatrists, psychologists, counselors and psychotherapists** who have treated your child in the recent past:

| Name | Telephone #<br>(optional) | Profession/Specialty | Dates of treatment |    |
|------|---------------------------|----------------------|--------------------|----|
|      |                           |                      | From               | To |
|      |                           |                      |                    |    |
|      |                           |                      |                    |    |
|      |                           |                      |                    |    |

Does your child have any **ALLERGIES** to medications? (circle one) YES NO

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

What **medications and remedies** is your child currently taking? This includes over-the-counter medications, homeopathic and herbal remedies and nutritional supplements.

| Name | Dose or quantity per day | When did she/he start it? |
|------|--------------------------|---------------------------|
|      |                          |                           |
|      |                          |                           |
|      |                          |                           |

Please list any **hospitalizations or surgeries** your child has had:

| Reason for hospitalization or surgery | Date |
|---------------------------------------|------|
|                                       |      |
|                                       |      |

| <b>Medical History</b><br>Please check the health problems that apply to each family member | c<br>h<br>i<br>l<br>d | f<br>a<br>l<br>l<br>e<br>r<br>r | m<br>a<br>t<br>e<br>r<br>n<br>a<br>l | s<br>i<br>b<br>l<br>e<br>i<br>n<br>p<br>a<br>r<br>e<br>n<br>t | <b>Medical History</b><br>Please check the health problems that apply to each family member | c<br>h<br>i<br>l<br>d | f<br>a<br>l<br>l<br>e<br>r<br>r | m<br>a<br>t<br>e<br>r<br>n<br>a<br>l | s<br>i<br>b<br>l<br>e<br>i<br>n<br>p<br>a<br>r<br>e<br>n<br>t |
|---|-----------------------|---------------------------------|--------------------------------------|---|---|-----------------------|---------------------------------|--------------------------------------|---|
| Alcoholism/Drug Abuse   |                       |                                 |                                      |   | High Blood Pressure   |                       |                                 |                                      |   |
| Allergies/Hayfever  |                       |                                 |                                      |   | HIV, AIDS   |                       |                                 |                                      |   |
| Anemia  |                       |                                 |                                      |   | Kidney Disease  |                       |                                 |                                      |   |
| Arthritis/Rheumatism  |                       |                                 |                                      |   | Learning Disabilities   |                       |                                 |                                      |   |
| Asthma  |                       |                                 |                                      |   | Liver Disease, Hepatitis  |                       |                                 |                                      |   |
| Birth Defects   |                       |                                 |                                      |   | Mental Illness  |                       |                                 |                                      |   |
| Bleeding Problems   |                       |                                 |                                      |   | Migraine Headaches  |                       |                                 |                                      |   |
| Cancer or Tumor   |                       |                                 |                                      |   | Nervous Breakdown   |                       |                                 |                                      |   |
| Colitis or Crohn's  |                       |                                 |                                      |   | Obesity   |                       |                                 |                                      |   |
| Congenital Heart Disease  |                       |                                 |                                      |   | Peptic Ulcer Disease  |                       |                                 |                                      |   |
| Depression  |                       |                                 |                                      |   | Psoriasis, Eczema   |                       |                                 |                                      |   |
| Diabetes  |                       |                                 |                                      |   | Rheumatic Fever   |                       |                                 |                                      |   |
| Ear infections--frequent  |                       |                                 |                                      |   | Stroke  |                       |                                 |                                      |   |
| Eczema  |                       |                                 |                                      |   | Suicide (or attempted)  |                       |                                 |                                      |   |
| Epilepsy, Seizures  |                       |                                 |                                      |   | Throat infections-frequent  |                       |                                 |                                      |   |
| Frequent Infections   |                       |                                 |                                      |   | Thyroid Disease   |                       |                                 |                                      |   |
| Genetic Disease   |                       |                                 |                                      |   | Tuberculosis  |                       |                                 |                                      |   |
| Herpes  |                       |                                 |                                      |   | Other:  |                       |                                 |                                      |   |
| Heart Disease/Heart Attacks   |                       |                                 |                                      |   | Other:  |                       |                                 |                                      |   |

**Eating Habits and Nutrition**

How many ounces of **milk** does your child drink each day? \_\_\_\_\_

**What kind** of milk ? (circle all that apply)

Breastmilk      Formula      Soy milk      Other: \_\_\_\_\_

Did your child ever breastfeed? (circle one)    YES    NO

If yes, how many months?\_\_\_\_\_.

What **foods** does your child eat on a regular basis?

|                       |  |
|-----------------------|--|
| Breakfast foods       |  |
| Lunch foods           |  |
| Dinner foods          |  |
| Foods he/she craves   |  |
| Foods he/she dislikes |  |
| Snack foods           |  |
| Comfort foods         |  |
| Food allergies        |  |

Would you like to discuss your child’s eating habits and diet? (circle one)    YES    NO

**School and Daycare**

Is your child currently enrolled in childcare, preschool, or school? (circle one)    YES    NO

If yes,where?\_\_\_\_\_

What grade is he/she in? \_\_\_\_\_

If not in school, who cares for your child at home? \_\_\_\_\_

Do you think that your child has any **difficulties with learning**? (circle one)    YES    NO

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns about the way that your child interacts with other children?

(circle one)    YES    NO      If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

What **extracurricular activities** does your child do in a typical week?

| Activity Type | Times per week |
|---------------|----------------|
|               |                |
|               |                |
|               |                |

**Sleep**

What time does your child go to **bed**?\_\_\_\_\_AM / PM    **Wake up**?\_\_\_\_\_ AM / PM

**Where** does he/she sleep?\_\_\_\_\_

Do you have any concerns about your child’s **sleep**? (circle one)    YES    NO

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns about your **child's bowel movements or bathroom habits**?  
(circle one) YES NO If yes, please explain:

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Does your **child spend time** with anyone who **smokes cigarettes**? (circle one) YES NO  
If yes, please describe: \_\_\_\_\_

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What are the greatest sources of **stress** in your child's life?

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What are the greatest sources of **comfort** in your child's life?

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Who are the people, including family members, **who play a very important role in your child's life**?

| Name | Relationship to child | Age | Do they live with your child?<br>(yes/no) |
|------|-----------------------|-----|---|
|      |                       |     |   |
|      |                       |     |   |
|      |                       |     |   |
|      |                       |     |   |
|      |                       |     |   |

Has your child, or another family member, ever experienced **sexual or physical abuse**?  
(circle one) YES NO If yes, please explain: \_\_\_\_\_

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**Information about the parents:**

How would you describe your parenting style? \_\_\_\_\_

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Do you have any concerns about **parenting**? (circle one) YES NO  
If yes, please describe:

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What is/are your **job(s) or occupation(s)** \_\_\_\_\_

Are you satisfied with your work? (circle one) YES NO

If no, please describe: \_\_\_\_\_

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Is there anything about your **work that negatively affects your mental or physical health**?

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What is your current annual **household income**? (circle one)

<\$20,000                      \$20,000-\$40,000                      \$40,000-\$60,000                      \$60,000-\$80,000  
\$80,000-\$100,000                      \$100,000-\$200,000                      >\$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? (circle one) YES NO  
If yes, please describe:

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Do you have any **concerns** about your current **LIVING** situation? (circle one) YES NO  
If yes, please describe:

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Do you belong to an **organized religion or spiritual group**? (circle one) YES NO  
If yes, please describe:

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Is there **any other information** about your child that you feel is important?

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Thank you,

Daphne Miller, MD  
Avril Swan, MD  
Alex Zaphiris, MD

FAMILY PRACTICE