Welcome to COPA!

Date _____

Child's name: _____Birthdate: _____Age _____
For non-newborns, where did you move from? _____
Prior pediatrician/family doctor: _____

Social History

Is this your child by ☐ Birth ☐ Adoption ☐ Step-child ☐ Foster-child ☐ Other: _____
Parents: ☐ Married ☐ Divorced ☐Separated ☐ Unmarried ☐ Other: _____
Are there any smokers in the household?: ☐ No ☐ Yes: ☐ inside ☐ outside
Pet/animal exposures at home: ☐ No ☐ Yes: types: _____

Family and/or Household Members:

Name	Relationship	Age	Occupation	DOB	Lives in home?
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no

Birth History: Where was your child born? _____
Were there any complications during pregnancy? ☐ no ☐ yes: _____
☐ Term ≥37 weeks ☐ Preterm: Weeks gestation: _____
Delivery was: ☐ vaginal ☐ C-Section: reason: _____
Birth weight: _____
Complications during/after delivery: ☐ no ☐yes: _____
Hepatitis B vaccine given: ☐ Yes ☐ No
Newborn hearing screen: ☐ Passed ☐ Referred/failed

Allergies: Does your child have any allergies to medications or foods? ☐ Yes ☐ No
Type of allergy and reaction: _____

Medications: Does your child take fluoride pills or drops? ☐ Yes ☐ No
Does your child take any other medications (even if used intermittently)? ☐ Yes ☐ No

Medication	Dose
_____	_____
_____	_____
_____	_____

Past Surgical History: Was a circumcision done? ☐ Yes ☐ No
Has your child had any prior surgeries? ☐ Yes ☐ No
Type of surgery and age/date: _____

Hospitalizations: Has your child been hospitalized overnight (except for surgery)? ☐ Yes ☐ No
Comments and age/date: _____

Past Medical History: Has your child had any of the following?

Condition:	Yes	No	
Allergies or Hay fever			
Anemia			
Anxiety			
Asthma or reactive airway disease			
ADHD			
Bleeding or clotting disorders			
Broken bones, fractures			
Chicken Pox			
Concussion or major head injury			
Constipation			
Depression			
Developmental delay			
Diabetes			
Drug or alcohol use			
Eczema			
Fainting			
Frequent ear infections			
GI reflux or heartburn			
Gastrointestinal disease			
Hearing problems			
Heart murmur or heart problems			
Hypertension or high blood pressure			
Learning disability			
Migraines			
Pneumonia			
Poor growth or failure to thrive			
Seizures			
Speech delay			
Thyroid problems			
Urinary tract infections or kidney disease			
Vision problems			
Other:			

Family History: Parental Heights: *Mom _____ *Dad _____

Check conditions that run in your child's family and indicate family member's relationship to child:

Relationship	Name	Status	No Known Problems	Arthritis-Rheumatoid	Arthritis-Osteo	Asthma	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Hip Dysplasia	Migraines	Rashes/Skin	Seizures	Stroke	Other: ___	Other: ___
Mother																		
Father																		
Sister																		
Brother																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:																		

☐ Adopted ☐ Family History Unknown