Rana Khoury MD
3736 Pelham Rd
Dearborn MI 48124

Name:

Birthdate:

Child's Name___________________________________ Age Today_________ Date__________
Previous Physician____________________________ Referred By__________________________
BIRTH HISTORY: Adopted? Yes____ No____ If "Yes", Is Child Aware? Yes____ No______
Date Of Birth___________ Hospital_________________ Birth Weight_______ Length_______
Prenatal Problems? Yes____ No____ If "Yes", Please List:_____________________________
____
Full Term Or Premature____
Type Of Delivery: Vaginal__________ C-Section__________
Regular Nursery? Yes_____ No_____
NICU Or Special Care Nursery? Yes_____ No______
If "Yes", Reason:____
Problems After Birth Or During First Week (0= None)
Breathing Problems____
Convulsions ____
Jaundice ________ If "Yes", Was Treatment Needed?___________________
Feeding Problems ____
Heart Problems ____
Hips ____
Other ____
Breast Fed (How Long?) ____
Bottle Fed (type(s) Of Formula)____
SOCIAL HISTORY: Who Does Child Live With? Mother____ Father____ Both____ Other____
Mother's Name_____________________________ Age_____ Health________________________
Occupation__________________________ Education (Last Grade)__________________
Father's Name______________________________ Age_____ Health________________________
Occupation___________________________ Education (Last Grade)__________________
Brother____________________________________ Age_____ Health________________________
Brother____________________________________ Age_____ Health________________________
Sister ____________________________________ Age_____ Health________________________
Sister ____________________________________ Age_____ Health________________________
Parent's Marital Status: Married_______ Divorced_______ Never Married_____ Separated____
If Divorced,Who Has Legal Custody?____
Residence: City Name_____________ House____ Apartment____ Flat____ Mobile Home_____
Who Lives In Home?____
Child's School_______________________ Grade___ Grades: Above Avg ___ Avg ___ Poor___
Preschooler's: In Day Care? Yes___ No___ If "Yes", Number Of Days Per Week___________
Name Of Sitter/ School____
Developmental Milestones: Child Walked At Age_____________ Few Words At Age_______
Toilet Trained At Age______________________
Allergies__________________________________ Current Medications______________________

PAST MEDICAL HISTORY: (Check all that apply)

__Roseola (baby measles)
__Rubella (german or 3 day measles)
__Rubeola (hard or 7 day measles)
__Bowel Problems
__School Problems
__Scarlet Fever
__Wheezing or Asthma
__Hives/Skin Problems
__Sutures/ Stitches
___Mononucleosis
___Bladder Infection
___Diabetes
___Menstrual Problems
___Mumps
___Strep Throat
___Seizures
___Behavior Problems
___Other
___Pneumonia
___Heart Murmur
___Fainting
___Fracture
___Chickenpox
___Ear Infection
___Bed-Wetting
___Age Of 1st Period

Previous Hospitalizations/ ER Visits____

Give Name Of Hospital, Type Of Problem, Child's Age. If None, Please Write None:_________

____

RISK FACTORS:

Smoker's In Home? Parents ___Yes ___No / Sitter ___Yes ___No / Grandparents ___Yes __No

Guns In Home? ___Yes ___ No, If "Yes", Are They Locked And Unloaded?________________

Smoke Detector In Home? ___Yes ___ No

FAMILY HISTORY:

Medical Problems (relatives of the patient)

0= None F=Father M=Mother S/B=Sister/Brother GP=Grandparent
A/U=Aunt/Uncle GGP=Great Grandparent

	0	F	M	S/B	GP	A/U	GGP
Tuberculosis (T.B.)							
Allergy/ Asthma							
Heart Attack Before Age 40							
Diabetes							
Hypoglycemia (Low Blood Sugar)							
Convulsions							
Heart Disorder							
Cancer							
Hypertension (High Blood Pressure)							
Arthritis							
Kidney/ Bladder Disorder							
Stroke							
Bleeding Disorder							
Muscle Disorder							
Developmental Delay or Retardation							
Other							

History of Birth Defects____________________________ History of S.I.D.S._______________

Signature of Informant_____________________________________ Date___________________ Reviewed By
Provider______________________________________ Date___________________