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	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?

Condiiton:	**Yes**	**No**	
Allergies or Hayfever			
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 track infections or kidney disease			
Vision problems			

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

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

Condition		**Relationship**	**Condition**		**Relationship**
Allergies (hayfever)			Eczema		
Alcohol abuse			Genetic disorders		
Anemia			Hearing loss		
Anxiety			Heart disease <50 y/o		
ADHD			High cholesterol		
Asthma			Hypertension		
Autoimmune disease			Kidney disease		
Bipolar disorder			Learning disabilities		
Bleeding/clotting disorder			Migraines		
Celiac disease			Obesity		
Congenital heart disease			Scoliosis		
Depression			Seizures		
Developmental delay			Sudden death		
Diabetes, type 1 (juvenile)			Thyroid disease		
Drug abuse					