NEW PATIENT HISTORY FORM

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DATE / /

NAME BIRTHDAY / /

How were you referred to our practice? _____

Current problems/Concerns: _____

Allergies (Medications, Vaccines, Food, others): _____

Current Medications: _____

BIRTH HISTORY

Was this child? ☐ Full Term ☐ Pre-Term ☐ Adopted If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? ☐ Vaginal ☐ C-Section If C-section, why? _____

Any problems during the newborn period? _____

Birth weight: _____ Breech? ☐ Yes ☐ No Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

CHILD'S PAST MEDICAL HISTORY

Any Hospitalizations? ☐ Yes ☐ No Any Surgeries? ☐ Yes ☐ No Any Emergency room or urgent care visits? ☐ Yes ☐ No

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

ADHD/ADD	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Urinary tract infection	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No	Acne	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Serious injury or concussion	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Ear Infections	☐ Yes	☐ No	Developmental and/or speech problems	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Fractures	☐ Yes	☐ No

For girls only, has she started her menstrual cycle? ☐ Yes ☐ No

Other history of chronic problem? _____

Has your child ever been seen by a specialist? _____ If so, please describe? _____

HAS YOUR CHILD EVER HAD:

Fainting during or after exercise, emotion or startle? ☐ Yes ☐ No

Extreme shortness of breath with exercise? ☐ Yes ☐ No

Discomfort, pain, or pressure in chest during exercise? ☐ Yes ☐ No

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grand Parent
High Blood Pressure				
High cholesterol				
Prolonged QT				
Early heart attack (under 50 yrs. old)				
Sudden unexplained death				
Anemia				
Bleeding or clotting disorder				
Allergies				
Autoimmune disorder				
Cancer				
Development/genetic disease				

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Condition	Mother	Father	Sibling	Grand Parent
Diabetes				
Thyroid Disease				
Polycystic Ovarian Syndrome (PCOS)				
Ear tubes/deafness				
Stomach problems				
Liver disease				
Celiac disease				
ADD/ADHD				
Migraines				
Autism				
Seizures				
Mental illness				
Drug addiction/alcohol abuse				
Asthma				
Tuberculosis				
Kidney problems				
Lazy eye				
Hip dysplasia				
Other (Please specify)				

SOCIAL HISTORY

Who lives in your child's home?_____

If parents are not living together or if child does not live with parents, what is the child's custody status? _____

Is your child in: ☐ Daycare ☐ School ☐ Home School If so, what grade? _____

Does anyone in the house smoke? ☐ Yes ☐ No If there are guns in the home, are they locked/secured? ☐ Yes ☐ No

Do you have any concerns about your child's school performance?_____

Do you have any special concerns about your child? _____

Is there anything more you would like us to know about your child?_____

_____

_____

FORM COMPLETED BY:

Name: _____ _____ Relation To Patient: _____

First Middle Last