New Patient History

Today's Date ________________

Child's Name ________________________________ **DOB** ___/___/___ **Gender M F**

Allergies to Medications ________________ **Routine Medications** ________________

<u>Family History</u> (please write in affected family member on blank below if any of the following medical history applies): ADHD/ADD, Allergies, Anemia, Asthma, Depression, Developmental Issues, Diabetes, Heart Disease, High Cholesterol, Hypertension, Immune system problems, Kidney problems, Malignancies/Cancer (please specify), Mental Illness, Migraines, Seizures, Substance Abuse, Tuberculosis, or Other Problems/Illnesses

Mother ____
Father ____
Brother(s) ____
Sister(s)____
Maternal Grandmother ____________________________________
Maternal Grandfather_____________________________________
Paternal Grandmother_____________________________________
Paternal Grandfather______________________________________
Maternal Aunt(s)____
Maternal Uncle(s)____
Paternal Aunt(s)____
Paternal Uncle(s)____
Cousin(s)____

<u>Social History</u>

Diet: Regular, Vegetarian, Vegan, Gluten Free Diary Free Other____________
Parents Marital Status: Married, Never Married, Separated, Divorced, Widowed
Child Lives With? Parents Mom Dad Relative Foster Parents Other___________
Sibling Name and Ages: ____________________________________

Childcare?	Yes	No	Relative Sitter/ Nanny Day Care/ School
Pets at Home?	Yes	No	Type ________________
Passive Smoke Exposure?	Yes	No	Who________________
Smoke and CO detectors?	Yes	No	
Seat belts / car seats?	Yes	No	
Sunscreen used routinely?	Yes	No	
Guns in Home?	Yes	No	Locked? Yes No

Child's school and grade if applicable: ______________________________

Pool Exposure?	Yes	No
Bike Helmet?	Yes	No

Any other issues at home or school you would like to discuss?____________________

____

Child's Medical History

Prenatal History: Any problems during pregnancy? (Circle all that apply)

Diabetes Infection Abnormal Bleeding Abnormal Fetal Ultrasound Abnormal Labs

Other: ____

Birth History: (Circle all the apply)

Vaginal delivery C- section Full Term Premature Birth Weight__________

Issues after delivery? NICU Admit Jaundice Difficulty Breastfeeding Tongue Tie

Other: ____

Past Medical History: (Circle all that apply)

ADD/ ADHD	Chicken Pox	Headaches/ Migraines
Allergies/ Hay fever	Congenital Anomalies	Head injury/ Concussion
Anemia	Constipation	Heart Problems
Anxiety	Depression	Mental Illness
Autism Spectrum	Developmental/ Behavioral	Muscle/Joint/Bone Disease
Bed Wetting	Diabetes	Seizures/ Epilepsy
Bladder/ Kidney	Difficulty Swallowing	Skin Problems/ Eczema
Blood diseases	Ear infections (chronic)	Thyroid Disorders
Cancer	Hearing Problems	Vision Problems

Comments/ Other: ____

Surgeries: Yes No

Circumcision Tongue Clip Ear Tubes Tonsils Removed Adenoids Removed Hernia Repair

Other: ____

Hospitalizations: Yes No

When/ Why: ____

Any other health issues we should be aware of? ______________________________

____

____