

**New Patient Health History**

**Child’s Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_

*Birth History:*

Mother’s pregnancy was (check one):

 □ Healthy and uncomplicated

 □ Complicated - list problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Not sure or don’t know (for example, if your child was adopted)

Delivery

 □ Normal Vaginal Delivery

 □ C-Section

□ Not sure or don’t know (for example, if your child was adopted)

Child was born: □ on time □ Early (How early? \_\_\_\_\_\_\_\_) □ Late □ Not sure

Where was child born: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight (approximate is ok): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Not sure

Right after birth:

 □ Baby was healthy and went home in a few days

 □ Baby had some problems - list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Baby had to stay in the special care nursery / NICU

 □ Not sure

*Medical History*

Please check any of the following problems your child has (or has had):

□ Asthma

□ Birth defects

□ Genetic disease

□ Thyroid /gland disease

□ ADHD

□ Cancer (type: \_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Diabetes

□ Behavior problems

□ Immune problems

□ Learning or school problems

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Anything else that worries or

 concerns you. \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the items you checked (when they started, how often, how bothersome, etc.)

*Other medical history:*

Have you had to take your child to the emergency room or walk-in clinic in the past year?

 □ No □ Yes - for what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been admitted to the hospital overnight?

 □ No □ Yes - for what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous traumatic injuries: □ None or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Broken bones, concussions, etc.)

Child’s previous surgeries: □ None or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Ear tubes, tonsillectomy, appendectomy, etc.)

Child’s current medications: □ None or\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Don’t forget supplements, inhalers, creams, etc.)

Child’s allergies: □ None or\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Continued on next page)*

Review of Systems- Please circle any of the following problems your child has (or has had):

 **General**

Anorexia

Birth defects

Developmental delay

Genetic disease

Growth Problems

Learning or school problems

**Eyes**

Eye Pain

Vision loss

Excessive tears

Itching

Blurring

Diplopia (double vision)

Irritation

Discharge

Photophobia (sensitive to light

**Ears/Nose/Throat**

Earache

Ear discharge

Decreased hearing

Nasal congestion

Nosebleeds

Sore throat

Cough (more than normal)

**Cardiovascular**

Heart defects

Syncope (fainting)

Hypertension (high blood pressure)

**Respiratory**

Wheezing

Dyspnea (shortness of breath)

**Gastrointestinal**

Constipation

Diarrhea

Vomiting

Reflux or heartburn

Nausea

Abdominal Pain

Bowel or liver problems

Jaundice

**Genitourinary**

Bedwetting (> age 6)

Urinary tract infections

Wet diaper every 2 to 4 hours

**Musculoskeletal**

Back pain

Joint pain

Scoliosis

**Skin**

Rash

Itching

Bleeding problems

Dryness

**Neurological**

Headaches

Seizures

Weakness

**Psychiatric**

Depression

Anxiety

Suicidal Ideation

 **Endocrine**

Polydipsia (increased thirst)

Polyphagia (excessive appetite)

Polyuria (excessive urination)

Weight Change

Cold intolerance

Heat intolerance

*Family history:*

Please check any history related to child’s mother or father.

□ Asthma

 □ Mother □ Father

□ Allergies – Seasonal

 □ Mother □ Father □ Behavioral problems

 □ Mother □ Father □ Birth defects

 □ Mother □ Father □ Cancer (type:\_\_\_\_\_\_\_\_)

□ Diabetes (adult or juvenile) □ Mother □ Father □ Genetic diseases

 □ Mother □ Father

□ Heart attacks

 Under age 55? Y N )

 □ Mother □ Father □ Heart disease

 (besides heart attacks)

 □ Mother □ Father □ High blood pressure

 □ Mother □ Father □ High cholesterol

 □ Mother □ Father □ Immune problems

 □ Mother □ Father

□ Learning Problems

 □ Mother □ Father

□ Mental illness

 □ Mother □ Father □ Addiction

 □ Mother □ Father □ Miscarriages or Stillbirths □ Mother □ Father □ Seizures

 □ Mother □ Father □ SIDS/ Crib death

 □ Mother □ Father □ Other – list: \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Social history:*

Who lives at home with the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pets at home: □ No □ Yes – what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smokers at home: □ No □ Yes

Family’s water supply: □ City water □ Well water

Child: □ goes to school/day care at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ is home schooled □ is too young for school

Child is in \_\_\_\_\_ grade Special educational needs? □ No □ Yes

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list anything else about your child or his environment that might be helpful for us to know (Recent stresses in the family, special religious or faith needs, etc.)