NEW PATIENT HISTORY FORM

Date ____________________________

Name _____________________________________ DOB: ______________________

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

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

ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Chicken Pox	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem? ____

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

____

HAS YOUR CHILD EVER HAD:

	Yes	No
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

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	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome (PCOS)	☐	☐	☐	☐
Ear tubes/deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

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? ____________ If so, what grade? ____________

Does anyone in the house smoke? __________________________

If there are guns in the home, are they locked/secured? _______________________________________

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: ________________________ Relationship to child________________________