New Patient History 2019

Today's Date _____ _____ _____

Child's Name | Date of Birth

Person completing form: _____ Relationship to child: _____

GENERAL HISTORY

	No	Yes	Explain
Is your child in good health?			
Ever been hospitalized (except at birth)?			
Ever had surgery (other than circumcision)?			
Any food allergies?			
Any medication allergies?			
Any concerns about your child's:			
Physical development			
Mental development			
Social/emotional development			
Weight or growth			
Attention span			
Learning/school performance			
Does your child have a dentist?			
Does your child see any specialists?			

Please explain any additional details on page 3.

SOCIAL HISTORY

Please list everyone who lives at home

(use page 3 if additional space is needed)

Name	Relationship to child	Age

Pets ❑ No ❑ Yes

Smokers in home ❑ No ❑ Yes

School or daycare ❑ No ❑ Yes

BIRTH HISTORY

Birth Weight _____

How many weeks at birth? _____

Delivery ❑ Vaginal ❑ Cesarean Why? _____

Any abnormalities at birth? ❑ No ❑ Yes Explain _____

Any complications during or after birth? ❑ No ❑ Yes

Was child admitted to the NICU? ❑ No ❑ Yes

Did Mom have any medical problems during this pregnancy?

❑ No ❑ Yes Explain _____

Did Mom take any medications during pregnancy? ❑ No ❑ Yes

Explain _____

Did Mom use alcohol, tobacco, or drugs during pregnancy?

❑ No ❑ Yes Explain _____

Did mom breastfeed? Breast, formula, or both _____

Do you have any concern about:	No	Yes	Explain
Abuse, family violence or exposure to violence			
Unsafe neighborhood or school			
Tobacco, alcohol, or drug use			
Having enough to eat or healthy food to eat			
Having a place to live			
Exposure to toxins (mold, lead, etc.)			
Death in the family or loss of parent due to divorce			
A safe place for your child to play and be active			

Additional room for explanation on page 3

PAST MEDICAL HISTORY

Has your child had any of the following problems?

Condition	No	Yes	Details
Abnormal newborn screening			
Chickenpox			
ADD/ADHD or behavior problems			
Depression, anxiety, mood or mental health issue			
Blood transfusion			
Autism, developmental delay, speech or motor delay			
School problems or learning difficulties			
Hearing problems			
Frequent ear infections, fluid, tubes			
Seasonal/environmental nasal allergies			
Asthma or frequent "bronchitis"			
Eczema			
Recurrent pneumonia or sinus infections			
Immune deficiency			
Anemia, bleeding problems or blood disorder			
Eye or vision problems			
Heart murmur or heart problem or high blood pressure			
Frequent abdominal pain			
Constipation requiring medical treatment			
Chronic diarrhea			
Lactose intolerance, celiac disease or gluten sensitivity			
Bladder or kidney infection			
Kidney, urinary, or genital problem			
Frequent headaches or dizziness			
Seizures or convulsions			
Concussion or head injury			
Broken bones or serious injury			
Overweight or obesity			
Diabetes, thyroid or any endocrine problems			
Early or late puberty			
Eczema or other skin problem			
Cancer			
Muscle, bone or joint problem			
Sleep problems or snoring			
Feeding problems			
Genetic or metabolic problem			
Liver problem			
High cholesterol or triglycerides			
Growth problem			
Elevated lead level			
Dental problems or cavities			

PRE-TEENS/TEENS/YOUNG ADULTS

Condition	No	Yes	Details
Sexually transmitted infection			
Pregnancy or miscarriage			
Tobacco, alcohol, or drug use			
Exposure to violence			
History of abuse or exposure to abuse			
Females: have periods started? What age?			
Any problems with periods?			

SPECIALISTS/OTHER CARE PROVIDERS

Specialist	Speciality (ENT, ortho,GI, speech therapy, etc.)	Condition	Details
Dentist:			

SURGICAL HISTORY

Surgery/Procedure	Age/Date	Where performed	Details

HOSPITALIZATON HISTORY

Reason/Diagnosis	Age/Date	Which hospital	Details

Other medical, family, surgical or hospital history, people at home, or other details or concerns you may have

_____

_____

_____

_____

_____

_____

PLEASE SEE NEXT PAGE

GENETIC FAMILY HISTORY

_____ _____

Biological Mother Biological Father

Use this form ONLY for children who have the SAME genetic (biological) father and mother.

MARK BOX IF any of your child's BIOLOGICAL/GENETIC parents, brothers or sisters, grandparents, aunts or uncles, ever had any of the following conditions (blood relatives only). B=brother; S=sister; GM=grandmother; GF=grandfather; A=Aunt; U=Uncle

				MOTHER'S SIDE			FATHER'S SIDE		
Condition	Mom	Dad	Full sibling B or S	Half- sibling B or S	Grandparent GM or GF	Aunt (A) or Uncle (U)	Half-sibling B or S	Grandparent GM or GFt	Aunt (A) or Uncle (U)
Example	✓		***S***	***S***	***GF***	***U***			***A***
Genetic or metabolic disease or syndrome									
Is anyone a carrier for any genetic disease									
Down syndrome or other chromosome problem									
Heart or any other defect present at birth									
Sudden, unexpected, or unexplained infant death									
Partial or total deafness hearing loss as a child									
Vision problem or blindness as a child									
Learning disabilities, mental retardation, or autism									
Developmental disability or disorder									
ADD/ADHD									
Seizures, convulsions or epilepsy									
Muscle disease or muscular dystrophy									
Eczema, many birthmarks, or other skin condition									
Bleeding disorder or hemophilia									
Severe anemia, sickle cell trait or disease									
Asthma, serious lung disease, or cystic fibrosis									
Severe allergies or eczema									
Heart disease, heart attack, or stroke before age 55 in males or 65 in females									
Marfan syndrome or heart arrythmia									
Implanted pacemaker or defibrillator									
Sudden or unexplained death before age 50									
Unexplained fainting, drowning, car accident									
Childhood cancer or leukemia									
Other cancer or tumors before age 50									
Diabetes in childhood or Type 2 diabetes									
Obesity									
High blood pressure/hypertension									
High cholesterol or triglycerides									
Kidney disease									
Thyroid or other hormone/endocrine problems									
Liver or celiac disease or bowel disease									
Depression or anxiety									
Other mental health condition or mood disorder									
Alcohol or substance abuse problems									