

NEW PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Person completing form: _____ Today's date _____

BIRTH HISTORY:

Birth Weight: _____ Mode of delivery: Vaginal/C-Section Complications: _____

Length of Pregnancy: _____ Hospital: _____

Complications or illnesses during pregnancy or after delivery: _____

PAST HOSPITALIZATIONS, SERIOUS ACCIDENTS, OR SURGERIES:

1. Reason/Diagnosis: _____

Date: _____

2. Reason/Diagnosis: _____

Date: _____

3. Reason/Diagnosis: _____

Date: _____

4. Reason/Diagnosis: _____

Date: _____

Has this patient had: (please circle yes or no)

Chicken Pox Yes/No (If Yes, please give mo/yr: _____)

If your child had Chicken Pox did he/she
have more than 10 pox? Yes/ No

Wheezing/Asthma Yes/No

Urinary Tract Infection Yes/No

Seizures/Convulsions Yes/No

Anemia Yes/No

Lead Poisoning Yes/No

Any other serious illnesses: _____

Medication/s patient is currently taking: _____

Please list any known medication, food, insect or other allergies and the nature of the reaction (rash/swelling, etc.) _____

Due to Genetic Pre-Disposition of certain diseases, we request your child's ethnic background. Please check all that apply:

	Father	Mother
African American	<input type="checkbox"/>	<input type="checkbox"/>
Asian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
Caucasian	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>
Native American	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify) _____		

Patient Name: _____ DOB: _____

FAMILY HISTORY:

Please circle yes if the child's parents, grandparents, siblings, aunts, or uncles have had the following illnesses and indicate the relationship to the child:

	<u>Detailed Information</u>
Asthma	Yes/No _____
Attention Deficit Hyperactive Disorder	Yes/No _____
Cancer	Yes/No _____
Diabetes	Yes/No _____
Hearing Loss/Deafness	Yes/No _____
Heart Disease/Heart attack before age 50	Yes/No _____
High Cholesterol	Yes/No _____
Hip problems/ hip dislocations	Yes/No _____
Kidney Disease	Yes/No _____
Learning disabilities	Yes/No _____
Mental illness, Anxiety or Depression	Yes/No _____
Mental Retardation	Yes/No _____
Seizure Disorder/Convulsions	Yes/No _____
Stomach/Bowel disease	Yes/No _____
Sudden or unexplained death before age 50	Yes/No _____
Thyroid disease	Yes/No _____
Lupus/Autoimmune disease	Yes/No _____
Tuberculosis	Yes/No _____
Other genetic conditions/diseases	Yes/No _____

SAFETY ISSUES:

1. Do you and your child wear a helmet and protective gear at all times when biking, rollerblading, skateboarding, and skiing? Yes/No
2. Are there any guns in the house? Yes/No
3. Does your drinking water have fluoride? Yes/No
4. Does your child visit the dentist every 6 months? Yes/No
5. Has your child had his vision checked in the past year? Yes/No
6. Does your child use a booster seat at all times? Yes/No
7. Are there smoke detectors, and carbon monoxide detectors in the home? Yes/No
8. Is the hot water temperature less than 125 degrees F? Yes/No
9. Are all medicines and potential poisons out of reach? Yes/No
10. Do you have the poison control number posted? Yes/No
11. Do you have a pool at home? Yes/No
12. How old is your house? _____
13. Are there any smokers in the household? Who: _____ Yes/No
14. Is your child exposed to second hand smoke on a regular basis? Yes/No

Any other information you would like the physician to know about your child _____

Thank you for taking the time to this form out. It will be reviewed by the physician and will become part of the medical record.

Reviewed by Physician _____

Date of Review _____