

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/Black	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
Caucasian	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic/Latin	<input type="checkbox"/>	<input type="checkbox"/>
Native American/Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
Prefer Not to Answer	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify) _____		

Languages Spoken at Home _____ Patient Preferred Language _____

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:

Detailed Information

Asthma	Yes/No _____
Attention Deficit Hyperactive Disorder	Yes/No _____
Cancer, please specify	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 _____
Anxiety	Yes/No _____
Depression	Yes/No _____
Mental Health Disease/Disorder (i.e. Bipolar, schizophrenia)	Yes/No _____
Cognitive Delay/Impairment	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? If yes, are they locked & inaccessible to children? Yes/No If yes, 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. Has your home been tested for radon? Yes/No
9. Is the hot water temperature less than 125 degrees F? Yes/No
10. Are all medicines and potential poisons out of reach? Yes/No
11. Do you have the poison control number posted? Yes/No
12. Do you have a pool at home? Yes/No
13. How old is your house? _____
14. Are there any smokers in the household? Who: _____ Yes/No
15. 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 _____

(Please use other side if you have more information to share with the physician)

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 _____