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	□	□
Asian	□	□
Caucasian	□	□
Hispanic/Latin	□	□
Native American/Alaska Native	□	□
Native Hawaiian/Pacific Islander	□	□
Prefer Not to Answer	□	□

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:

		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 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. 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 _____

_____

_____

_____

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_____