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 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________________

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