New Patient History Form

Patient Name: _____ **Date of Birth**: _____

Your Relationship to Patient: _____

Preferred Pharmacy: _____ Location: _____

Has your child been seen at another medical facility before today's visit? ☐ Yes ☐ No

Date of last exam: _____ Location/Provider: _____

Birth History

Hospital _____ Obstetrician/Practice_____

Type of delivery ☐ Vaginal ☐ C-Section Complications ☐ No ☐ Yes _____

Birth Weight _____ Birth Length _____ Discharge Weight _____ if applicable

Did your baby have any problems during the hospital stay, prior to being discharged home? ☐ No ☐ Yes

_____

Medical History

Is your child currently under the care of a physician for medical problems? ☐ No ☐ Yes

Please List: _____

Taking any medications? (prescription, over-the-counter, natural supplements) ☐ No ☐ Yes

Please list medication, dosage, frequency: _____

_____

_____

Has your child been hospitalized? ☐ No ☐ Yes _____

Has your child had any surgeries? ☐ No ☐ Yes _____

Does your child have any allergies: ☐ No ☐ Yes (Please list any medication or food allergies)

Allergic to: _____ What happens if they are exposed? _____

_____

Has your child had any history of or difficulty with any of the following:

Yes	No		Yes	No		Yes	No	
		Allergies			Cerebral Palsy			Hearing problems
		Asthma			Chicken pox			Heart problems
		AIDS/HIV			Constipation			Hepatitis

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		Anemia			Diarrhea			Kidney Disease
		Bedwetting			Diabetes			Liver Disease
		Birth defects			Drug/Alcohol abuse			Measles
		Bladder problems			Ear infections			Mononucleosis
		Bleeding, excessive			Epilepsy/Seizures			Mumps
		Cancer			Fainting			Pneumonia

Has your child had any history of or difficulty with any of the following:

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
		Rheumatic Fever			Tuberculosis			Mental Illness
		Sinus problems			Urinary Disease			Other
		Speech problems			Vision problems			
		Thyroid disease			Developmental delays			

Please describe, if not listed under past medical history: _____

Family History

Have any of the patient's family members been diagnosed with the following (if known):

Medical Problem	**Mom**	**Dad**	**Sibling**	**Maternal Grandparents**	**Paternal Grandparents**
Allergies					
Anemia					
Asthma					
Birth Defects					
Bleeding problems					
Cancer					
Seizures/Epilepsy					
Deafness					
Developmental Delay					
Diabetes					
Gastrointestinal problems					
Heart Disease					
High Cholesterol/Lipids					
High blood pressure					

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Headaches					
Joint problems/Arthritis					
Kidney Disease					
Menstruation/Period problems					
Mental Illness (Depression, Anxiety, Bipolar disorder, etc)					
Attention problems/ hyperactivity					
School difficulties					
Skin problems					
Sinus problems					
Thyroid disease					
Tuberculosis					
Vision problems					

If needed, please explain any family history problems: _____

_____

Developmental and Social History

List Age of Milestones (if applicable): Cooed or Laughed _____ Held Head Up _____

Sat up by self _____ First Word _____ Walked _____ Potty Trained _____

Do you have any concerns about your child's development? □ No □ Yes _____

_____

Does your child have any issues or difficulties in school? □ No □ N/A □ Yes _____

_____

Does your child participate in any activities outside of the home? (sports, community activities, church, etc)

□ No □ Yes Please List: _____

Who lives at home with your child? _____

Are both parents involved in your child's life? □ Yes □ No

Please list parents' names and occupations: _____

_____

Is there anyone else who takes care of your child on a regular basis? □ No □ Yes, please list name and relation/position: _____

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Is your child in daycare or an after school program? ☐ No ☐ Yes _____

Does anyone smoke in the home? ☐ No ☐ Yes

Do you have any pets at home? ☐ No ☐ Yes if yes, what kind? _____

How does your family like to spend time together? _____

_____

Who prepares the meals for your family? _____

How often does your family sit down for meals together? _____

How would you describe your child's eating habits: ☐ Eats a variety of foods ☐ Will try some new foods, but mostly eats the things he/she likes most ☐ Picky eater

How many hours does your child sleep at night? _____

Does he/she take naps during the day? ☐ No ☐ Yes, at what time(s)? _____

Does your child have any of the following sleep difficulties? ☐ Difficulty falling asleep ☐ Waking up in the middle of the night ☐ Difficulty waking up in the morning, Please describe: _____

_____

How often does your child get exercise and what does this look like? _____

_____

How does your child relax or key down from the day's activities? _____

_____

Is your family involved in any religious/spiritual practices or community? ☐ No ☐ Yes, please list:

_____

Would you like us to pray for your child during a visit? ☐ Yes ☐ No

Where and how does your family receive love and support? _____

_____

Is there anything else that you would like to share about your family? _____

_____

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What are your goals for your child's health? _____

_____

_____

_____

Are there any health topics that you are interested in learning more about for your child's health or in general? _____

_____

_____

Additional comments or questions?: _____

_____

_____

Thank you for taking the time to fill out this form. This information will be kept confidential and it will be used to guide your child's medical treatment plan. Please update our office with any changes to your child's medical status.

_____ _____

Signature of Parent/Guardian Date