New Patient Health History - Pediatric 0-5 years

Name _____ **Date of Birth** _____ **Today's Date** _____

Current Medical Concerns (what you would like to talk about today):

_____

_____

Please list any allergies your child has to medications:
Name of Med Reaction

_____

_____

Please list any medication your child currently takes, including Over the Counter Medications, Herbal Supplements, or Vitamins:
Name of Med Dose Directions (How often given)

_____

_____

Immunizations (shots)
Do you follow the recommended CDC vaccination schedule? ❒ Yes ❒ No
Please explain if altering schedule:_____

Has your child ever been hospitalized? ❒ Yes ❒ No If yes, please explain below:

_____

_____

Please check any surgeries your child has had: ❒ Heart ❒ Ear Tubes ❒ Tonsils/Adenoids ❒ Appendix ❒ Circumcision
❒ Frenulectomy (tongue clipping) ❒ Eye Surgery ❒ Hernia Repair, type: _____ ❒ Other:_____

Prenatal and Birth History
Did this child's mother receive prenatal care? ❒ Yes ❒ No
Any maternal illness/complications/infections during pregnancy? ❒ Yes ❒ No _____
Gestational age at birth: _____weeks
Type of delivery: ❒ Vaginal ❒ Planned C/S ❒ Unplanned C/S ❒ Forceps/Vacuum
Reason for unplanned C/S _____
Birth Weight: _____lbs _____oz Any complications with delivery? ❒ Yes ❒ No _____
Any complications with your child postpartum? ❒ Yes ❒ No _____
Days your child spent in hospital: _____ Hearing test: ❒ Passed ❒ Failed ❒ Unknown

FAMILY HEALTH HISTORY

Is your child adopted? ❒ Yes ❒ No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety and/or Depression								
Arthritis								
Asthma								
Bipolar or Schizophrenia								
Blood Disorder								
Cancer								
Developmental Disorder								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

ADHD or ADD	❒ Yes	❒ No	Ear or Hearing Problems	❒ Yes	❒ No
Allergies/Hayfever	❒ Yes	❒ No	Eczema	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	HIV	❒ Yes	❒ No
Anesthesia Complications	❒ Yes	❒ No	Heart Problems	❒ Yes	❒ No
Anxiety Disorder or Recurrent Anxiety	❒ Yes	❒ No	Kidney or Bladder Problems	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No
Autism Spectrum Disorder	❒ Yes	❒ No	Migraines	❒ Yes	❒ No
Birth Defects or Inherited Disease	❒ Yes	❒ No	Muscle, Joint, or Bone Problems	❒ Yes	❒ No
Blood Transfusion	❒ Yes	❒ No	Reflux/GERD	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Seizures/Epilepsy	❒ Yes	❒ No
Chicken Pox	❒ Yes	❒ No	Skin problems (Rashes/Changing Moles)	❒ Yes	❒ No
Clotting Problems/bleed too much	❒ Yes	❒ No	Stomach Ulcers or Swallowing Problems	❒ Yes	❒ No
Developmental or Behavioral Disorders	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Tuberculosis or Positive TB Test	❒ Yes	❒ No
Domestic Violence	❒ Yes	❒ No	Vision or Eye Problems	❒ Yes	❒ No
Ear Infections - Chronic	❒ Yes	❒ No	Other:	❒ Yes	❒ No