PEDIATRIC NEW PATIENT HEALTH HISTORY (3-11 YRS)

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your child and support for you.

Child's Name: _____ DOB: _____
Name of person filling out form: _____
I am this child's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: _____

Is your child taking any medications, vitamins, or supplements regularly? ❑ No ❑ Yes If yes, what: _____
_____
Does your child have any allergies (medicine, foods)? ❑ No ❑ Yes If yes, to what: _____
Has your child been vaccinated? ❑ No ❑ Yes Where did your child receive prior vaccinations? _____

CHILD'S HEALTH PROBLEMS (Check box if your child has had any of these)

- ❑ Anemia
- ❑ Asthma
- ❑ Birth defect: _____
- ❑ Bleeding problem
- ❑ Bone/joint/muscle problem
- ❑ Chicken pox
- ❑ Constipation
- ❑ Developmental delay
- ❑ Eczema
- ❑ Eye / Vision Problem
- ❑ Frequent ear infections
- ❑ Other: _____
- ❑ Hearing Problem
- ❑ Heart Problem/ Murmur
- ❑ Liver Problem
- ❑ Kidney / Bladder Problem
- ❑ Pneumonia
- ❑ Seizures / Epilepsy
- ❑ Sleep apnea
- ❑ Toothache / Decay
- ❑ Tuberculosis
- ❑ Urinary tract infection (UTI)

Has your child been hospitalized or had surgery? ❑ No ❑ Yes When / why: _____
_____
Was your child born early (premature)? ❑ No ❑ Yes If yes, how many weeks early? _____
Were there any problems during pregnancy or delivery? ❑ No ❑ Yes If yes, explain: _____
_____

FAMILY MEDICAL HISTORY (Check if your adolescent's biological siblings, parents, or grandparents have had any of the following):

	Relationship to adolescent		Relationship to adolescent
❑ Alcohol/drug problem	_____	❑ Hepatitis	_____
❑ Anxiety	_____	❑ High Blood Pressure	_____
❑ Asthma	_____	❑ High Cholesterol	_____
❑ Autism	_____	❑ Intellectual disability	_____
❑ Birth defect	_____	❑ Kidney disease	_____
❑ Bleeding disorder	_____	❑ Mental illness	_____
❑ Cancer	_____	❑ Seasonal allergies	_____
❑ Childhood hearing loss	_____	❑ SIDS	_____
❑ Developmental delay	_____	❑ Stroke before age 50	_____
❑ Depression	_____	❑ Thyroid problem	_____
❑ Diabetes	_____	❑ Tuberculosis	_____
❑ Eczema	_____	❑ Other:	_____
❑ Epilepsy/ Seizures	_____	_____	_____
❑ Heart problem before age 55	_____	_____	_____

Signature: _____ Date: _____