

NEW PATIENT HISTORY

GENERAL

Patient Name _____ Date of Birth _____ MALE / FEMALE Date _____

School: _____ Grade: _____

Mother's Name: _____ Father's Name: _____

Child Lives with: Both Parents Mother Father Other: _____ (please provide Certified copy of custody agreement or Divorce Decree)

If child does not live with parents how often does he/she get to see parents: _____

Name of any specialists Your child sees: _____

Reason for Visit: _____ Date problem began: _____

HOUSEHOLD

Please list all those living in the child's home (parents, siblings, grandparents, etc...)

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

Are there any pets living in house with child: YES NO If yes how many and what kind: _____

BIRTH HISTORY

Birth Weight: _____lb _____oz

Was the baby born at: Term Early Late

If early how many weeks gestation: _____wks

Did mother have any illness during or problems with pregnancy: YES NO

If yes explain: _____

During pregnancy did mother take any of the following:

Smoke: YES NO If yes how much: _____

Drink Alcohol: YES NO If yes how what and how much: _____

Drugs/Medications: YES NO If yes what and how often: _____

Was the delivery: Vaginal Cesarean

If cesarean why? _____

Did your baby have any problems immediately after birth: YES NO

If yes explain: _____

Was initial feeding after birth: Breast Bottle

Did baby go home with mom: YES NO

Explain: _____

Patient Name: _____

Date: _____

FEEDING AND NUTRITION

Is your child's appetite good? YES NO Explain: _____
 Do any foods disagree with your child? YES NO Explain: _____
 Did you child suffer from colic in first three months? YES NO Explain: _____
 Does your child take Vitamins or herbal supplements? YES NO Explain: _____
 For first 6 months was child breast or bottle fed? BREAST BOTTLE If bottle name of Formula: _____

DEVELOPMENTAL

Are you concerned about your child's physical development? YES NO Explain: _____
 Are you concerned about your child's emotional I development? YES NO Explain: _____
 Are you concerned about your child's attention span? YES NO Explain: _____
 Does your child have trouble sleeping? YES NO Explain: _____
 Does your child get along with other children? YES NO Explain: _____
 Did your child say any words by 1 ½ years old? YES NO If no at what age: _____
 What age did your child sit alone? _____

If your child is school aged:

How is his/her behavior in class? _____
 Has he/she ever failed/repeated a grade? _____
 How does he/she perform in academic subjects? _____
 Is he/she in special resource classes? YES NO If yes which ones: _____

CHILD'S MEDICAL HISTORY

Date of last Medical Exam: _____

Date of last Dental Exam: _____

Do you think your child is in good health? YES NO Explain: _____
 Does your child have any problems with teeth? YES NO Explain: _____
 Does your child have a serious medical condition? YES NO Explain: _____
 Has your child ever had a serious injury/ accident? YES NO Explain: _____
 Does your child suck thumb/ bite nails YES NO Explain: _____
 Does your child have problems controlling temper? YES NO Explain: _____

Please indicate if your child has ever had any of the following and explain illness:

MEDICAL CONDITION	YES	NO	EXPLANATION
Chicken Pox			
Ear Problems			
Nasal Allergies			
Throat Problems			
Eye Problems			
Asthma, Bronchitis, bronchiolitis, pneumonia			
Heart Problems			
Anemia, Bleeding problems, blood transfusion			
Abdominal Pain			
Bowel Problems			
Bladder / Kidney problems			
Bed Wetting (after 5 years old)			
Chronic / Recurrent Skin Problems (acne, eczema, etc)			
Headaches			
Neurological Problems (convulsions, seizures, etc.)			
Diabetes			
Thyroid			
For Girls: menstrual period began?			
For Girls: problems with menstrual period?			
Use of Drugs / Alcohol			
Other:			
Other:			

Patient Name: _____

Date: _____

Please indicate any surgeries/ hospitalizations your child has had:

TYPE OF SURGERY	DATE OF SURGERY

Please list any medications your child takes daily:

MEDICATION	STRENGTH	TIMES A DAY	REASON

Please list any medications/foods/insect bites that your child has had any type of reaction to or is allergic to:

MEDICATION/ FOOD/ INSECT BITES ALLERGY	REACTION

FAMILY HISTORY

MEDICAL CONDITION	YES	NO	RELATIVE	MEDICAL CONDITION	YES	NO	RELATIVE
Deafness				Kidney Disease			
Nasal Allergies				Diabetes (before age 50)			
Asthma				Bed Wetting (after age 10)			
Tuberculosis				Epilepsy or Convulsions			
Heart Disease (before age 50)				Alcohol Abuse			
High Blood Pressure (before age 50)				Drug Abuse			
High Cholesterol				Mental Illness			
Anemia				Mental Retardation			
Bleeding Disorder				Immune Problems (HIV/ AIDS)			
Liver Disease				Other:			

Parent/ Guardian Signature

Date