HEALTH HISTORY FOR NEW PATIENTS (Birth to age 12)

NAME: _____APPOINTMENT DATE _____

BIRTHDATE: _____AGE_____

PAST HEALTH HISTORY

PRENATAL OR NEWBORN COMPLICATIONS: _____

ANY HOSPITALIZATIONS OR SURGERIES: _____

Please list the name of each family member and any health:

Father:
Mother:
Siblings:
Other family:

Who lives with this child? _____

Childcare arrangements (i.e. home, daycare, sitter)? _____

MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION):

ALLERGIES:

IS THERE ANY TOBACCO USE IN THE HOUSEHOLD?

SLEEPING - TYPICAL WAKE AND SLEEP TIMES:

DISCIPLINE - HOW IS THIS APPROACHED AT HOME?

FAVORITE ACTIVITIES?

HOW MANY SCREEN HOURS OF TV/COMPUTER/VIDEO GAMES PER DAY?

HOW OFTEN IS CAR SEAT OR SEAT BELT USED WHEN RIDING IN A CAR?

DESCRIBE EATING PATTERNS, NUMBER OF MEALS PER DAY, DIETARY PROBLEMS:

NEW OR CONTINUING PROBLEMS: (circle any that apply)

General: Fevers or chills. Weight change. Appetite change
Eyes: Vision concerns. Eye discharge or discomfort.
Eye care provider and last exam: (Age 3 or older)_____
Ears: Change in hearing or ear pain. Nasal congestion or bleeding.
Mouth: Mouth sores, sore throat, dental problems
Dental provider and last exam: **(Age 3 or older)** _____
Heart: Chest pain or heart concerns
Lungs: Cough or shortness of breath.
Breasts: Pain, nipple discharge or masses
Bowels: Abdominal pain, change in bowels, bleeding, heartburn, spitting up
Urinary: Urinary problems, menstrual problems
Muscle/bone: Injuries, joint or muscle or back pain
Brain, spine: Speech or developmental concerns; headaches
Skin: Rashes or concerning lesions
Metabolism: Unusual thirst or weight loss.
Emotions: Depression or anxiety; school problems, fears
Allergy: Allergy symptoms

ANY ADDITIONAL CONCERNS YOU WOULD LIKE TO ADDRESS ?

NOTE THAT AN ADDITIONAL APPOINTMENT MAY BE NEEDED TO ADEQUATELY MEET YOUR CHILDS HEALTH NEEDS.

Thank you

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