New Patient Health History Form
(Pediatric)

REASON FOR VISIT		TODAY'S DATE	
LAST NAME	FIRST	DATE OF BIRTH	AGE
GENDER AT BIRTH ☐M ☐F	PRIMARY CARE PROVIDER		
FORM COMPLETED BY	RELATIONSHIP TO PATIENT		

HOUSEHOLD (LIST ALL THOSE LIVING IN THE CHILD'S HOME)

NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH	HEALTH PROBLEMS

ARE THERE ANY SIBLINGS NOT LISTED? ☐ **YES** ☐ **NO** **(If yes, please list below)**

NAME	DATE OF BIRTH / AGE	HEALTH PROBLEMS	WHERE THEY LIVE

WHAT IS THE CHILD'S LIVING SITUATION, IF NOT WITH BOTH BIOLOGICAL PARENTS?

☐ LIVES WITH ADOPTIVE PARENTS ☐ JOINT CUSTODY
☐ LIVES WITH FOSTER FAMILY ☐ SINGLE CUSTODY
☐ OTHER:

IF ONE OR BOTH PARENTS ARE NOT LIVING IN THE HOME, HOW OFTEN DOES THE CHILD SEE THE PARENT(S) NOT IN THE HOME?

BIRTH HISTORY

☐ **CHECK IF YOU DON'T KNOW BIRTH HISTORY**

BIRTH WEIGHT? LBS OZ		
WAS THE BABY BORN AT TERM?	☐YES ☐NO	HOW MANY WEEKS
WERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS?	☐YES ☐NO	IF YES EXPLAIN
WAS A NICU STAY REQUIRED?	☐YES ☐NO	IF YES EXPLAIN
WAS THE DELIVERY	☐VAGINAL ☐CESAREAN	IF CESAREAN, EXPLAIN WHY
WAS THE INITIAL FEEDING	☐FORMULA ☐BREAST MILK	HOW LONG BREAST FED?
DID THE BABY GO HOME WITH MOTHER FROM THE HOSPITAL?	☐YES ☐NO	IF NO, EXPLAIN
DURING PREGNANCY, DID MOTHER	☐USE TOBACCO?	HOW MUCH?
	☐DRINK ALCOHOL?	HOW MUCH?
	☐USE DRUGS OR MEDICATIONS?	WHAT? WHEN?
	☐USE PRENATAL VITAMINS?	

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MEDICATION HISTORY			
MEDICATION	**DOSAGE**	**HOW OFTEN?**	**PHARMACY**

GENERAL HEALTH				
DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HAS YOUR CHILD HAD ANY SURGERY?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HAS YOUR CHILD EVER BEEN HOSPITALIZED?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
IS YOUR CHILD ALLERGIC TO MEDICINE OR DRUGS?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
DO YOU FEEL YOUR FAMILY HAS ENOUGH TO EAT?	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN

BIOLOGICAL FAMILY HISTORY				
HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING?				
CHILDHOOD HEARING LOSS	☐ YES	☐ NO	☐ DON'T KNOW	WHO
NASAL ALLERGIES	☐ YES	☐ NO	☐ DON'T KNOW	WHO
ASTHMA	☐ YES	☐ NO	☐ DON'T KNOW	WHO
TUBERCULOSIS	☐ YES	☐ NO	☐ DON'T KNOW	WHO
HEART DISEASE (BEFORE AGE 55)	☐ YES	☐ NO	☐ DON'T KNOW	WHO
HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION	☐ YES	☐ NO	☐ DON'T KNOW	WHO
ANEMIA	☐ YES	☐ NO	☐ DON'T KNOW	WHO
BLEEDING DISORDER	☐ YES	☐ NO	☐ DON'T KNOW	WHO
DENTAL DECAY	☐ YES	☐ NO	☐ DON'T KNOW	WHO
CANCER (BEFORE AGE 55)	☐ YES	☐ NO	☐ DON'T KNOW	WHO
LIVER DISEASE	☐ YES	☐ NO	☐ DON'T KNOW	WHO
KIDNEY DISEASE	☐ YES	☐ NO	☐ DON'T KNOW	WHO
DIABETES (BEFORE AGE 55)	☐ YES	☐ NO	☐ DON'T KNOW	WHO
BED-WETTING (AFTER AGE 10)	☐ YES	☐ NO	☐ DON'T KNOW	WHO

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BIOLOGICAL FAMILY HISTORY (continued)				
OBESITY	☐ YES	☐ NO	☐ DON'T KNOW	WHO
EPILEPSY OR CONVULSIONS	☐ YES	☐ NO	☐ DON'T KNOW	WHO
ALCOHOL ABUSE	☐ YES	☐ NO	☐ DON'T KNOW	WHO
DRUG ABUSE	☐ YES	☐ NO	☐ DON'T KNOW	WHO
MENTAL ILLNESS/DEPRESSION	☐ YES	☐ NO	☐ DON'T KNOW	WHO
DEVELOPMENTAL DISABILITY	☐ YES	☐ NO	☐ DON'T KNOW	WHO
IMMUNE PROBLEMS, HIV OR AIDS	☐ YES	☐ NO	☐ DON'T KNOW	WHO
TOBACCO USE	☐ YES	☐ NO	☐ DON'T KNOW	WHO
ADDITIONAL HISTORY NOT LISTED				

PAST HISTORY				
DOES YOUR CHILD HAVE, OR HAS YOUR CHILD EVER HAD THE FOLLOWING?				
CHICKENPOX	☐ YES	☐ NO	☐ DON'T KNOW	WHEN
FREQUENT EAR INFECTIONS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
PROBLEMS WITH EARS OR HEARING	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
NASAL ALLERGIES	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
PROBLEMS WITH EYES OR VISION	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ASTHMA, BRONCHITIS, BRONCHIOLITIS OR PNEUMONIA	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ANY HEART PROBLEM OR HEART MURMUR	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ANEMIA OR BLEEDING PROBLEM	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
BLOOD TRANSFUSION	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HIV	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ORGAN TRANSPLANT	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
MALIGNANCY/BONE MARROW TRANSPLANT	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
CHEMOTHERAPY	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
FREQUENT ABDOMINAL PAIN	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
CONSTIPATION REQUIRING DOCTOR VISITS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
RECURRENT URINARY TRACT INFECTIONS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
CONGENITAL CATARACTS/RETINOBLASTOMA	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN

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PAST HISTORY (continued)				
METABOLIC/GENETIC DISORDERS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
KIDNEY DISEASE OR UROLOGIC MALFORMATIONS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
BED-WETTING (AFTER AGE 5)	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
SLEEP PROBLEMS/SNORING	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
CHRONIC OR RECURRENT SKIN PROBLEMS (ACNE, ECZEMA)	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
FREQUENT HEADACHES	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
OBESITY	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
DIABETES	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
THYROID OR OTHER ENDOCRINE PROBLEMS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HIGH BLOOD PRESSURE	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HISTORY OF SERIOUS INJURY/FRACTURES/CONCUSSIONS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
USE OF ALCOHOL OR DRUGS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
TOBACCO USE	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ADHD/ANXIETY/DEPRESSION	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
DEVELOPMENTAL DELAY	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
DENTAL DECAY	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
HISTORY OF FAMILY VIOLENCE	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
SEXUALLY TRANSMITTED INFECTIONS	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
PREGNANCY	☐ YES	☐ NO	☐ DON'T KNOW	EXPLAIN
ADDITIONAL HISTORY NOT LISTED				
FOR GIRLS				
PROBLEMS WITH PERIODS	☐ YES	☐ NO	☐ DON'T KNOW	WHO
HAS HAD FIRST PERIOD	☐ YES	☐ NO	☐ DON'T KNOW	AGE OF FIRST PERIOD