**Pediatric New Patient Health History (age 0-17years)**

**Patient Full Name: Date of Birth:**

**Allergies Reaction**

|  |  |
| --- | --- |
|  |  |
|  |  |

□ No Know Drug Allergies

**Current Medications, Vitamins and Supplements: Dose Frequency**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Preferred Pharmacy & Location:**

|  |
| --- |
|  |

**IMMUNIZATIONS:** □ Up to Date

**\*PLEASE BRING COPY OF CURRENT IMMUNIZATION RECORD TO 1ST APPOINTMENT. Thank you!**

□ Other:

**Do any caregivers Smoke or Vape?** □ yes □ no

**BIRTH HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| City, State |  | Hospital |  |
| Birth Weight |  | Gestational Age |  |
| Delivery | □ Vaginal □ Cesarean (explain below) | Feeding Method | □ Breast □ Formula |
| Hearing Screen | □ Pass □ Fail | Vitamin K shot | □ yes □ no |

Pregnancy complications? □ yes □ no Maternal Nicotine / Alcohol use? □ yes □ no

Maternal Drug / Rx use? □ yes □ no Maternal Immunosuppressant use? □ yes □ no

Birth defects / deformities? □ yes □ no Problems after birth? □ yes □ no

**If “yes” please explain:**

|  |
| --- |
|  |
|  |

**MEDICAL HISTORY** Briefly describe Incident or Medical ProviderDate

|  |  |  |  |
| --- | --- | --- | --- |
| Any Chronic Medical Conditions or Physical / Mental Diagnosis? | □ yes □ no |  |  |
| Any Serious Illness? | □ yes □ no |  |  |
| Any Major Injuries? | □ yes □ no |  |  |
| Any Hospitalizations? | □ yes □ no |  |  |
| Any Surgeries? | □ yes □ no |  |  |
| Meeting Pediatric Milestones? | □ yes □ no |  |  |
| Regular Dental Care? | □ yes □ no |  |  |
| Previous Provider / Specialist? | □ yes □ no |  |  |

**FAMILY HISTORY**

Patient currently lives with:

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of Birth** | **Relationship to patient** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Biological Parent or Siblings living elsewhere:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Relationship** | **City, State** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  | Status (alive / dscd) |  | Allergies | ADHD / ADD | Asthma | Birth defects | Cancer - TYPE | Clotting disorder | Depression | Diabetes | Hearing loss | Heart Disease | High Blood Pressure | High Cholesterol | Kidney Disease | Learning Disabilities | Mental Illness | Seizures | Stroke | Substance Abuse | Thyroid Disease | Vision Loss | OTHER |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maternal Grandmother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maternal Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Paternal Grandmother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Paternal Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

□ Adopted □ Family History Unknown □ No Known Problems

**SOCIAL HISTORY**

|  |  |
| --- | --- |
| Primary Language | □ English □ Spanish □ Other |
| Alternate Caregiver / Daycare |  |
| School | Grade: |
| School Services (IEP, 504, etc.) |  |
| Other Therapy (PT, OT, ST, etc.) |  |
| Recreational Activities |  |
| Pets | □ yes □ no Type: |