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Pediatric New Patient Health History – 0-5 years

Name _____ **Date of Birth**___/___/_____ **Gender** _____

Current Medical Concerns (what you would like to talk about today):

1. (most important)_____
2. _____
3. _____

Please list any ALLERGIES your child has to medications:
NAME OF MED Reaction

_____

_____

Please list any MEDICATIONS your child currently takes, including Over the Counter Medications, Herbal Supplements, or Vitamins:
NAME OF MED Dose Directions (How often given)

_____

_____

_____

Immunizations
Do you follow the recommended CDC vaccination schedule? NO YES

Please explain if altering schedule:_____

Has your child ever been hospitalized? Yes / No **If yes, please explain below:**

_____

_____

Please circle any surgeries your child has had: Heart Ear Tubes Tonsils/Adenoids Appendix

Circumcision Frenulectomy (tongue clipping) Eye Surgery Hernia Repair, type: _____

Other: _____

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Name (page 2) _____

Personal Health History:

ADHD or ADD	No ☐	Yes ☐	HIV	No ☐	Yes ☐
Allergies/Hayfever	No ☐	Yes ☐	Heart Problems	No ☐	Yes ☐
Anemia	No ☐	Yes ☐	Kidney or Bladder Problems	No ☐	Yes ☐
Anesthesia Complications	No ☐	Yes ☐	Liver Disease	No ☐	Yes ☐
Anxiety Disorder or Recurrent Anxiety	No ☐	Yes ☐	Migraines	No ☐	Yes ☐
Asthma	No ☐	Yes ☐	Muscle, Joint, or Bone Problems	No ☐	Yes ☐
Autism Spectrum Disorder	No ☐	Yes ☐	Reflux/GERD	No ☐	Yes ☐
Birth Defects or Inherited Disease	No ☐	Yes ☐	Seizures/Epilepsy	No ☐	Yes ☐
Blood Transfusion	No ☐	Yes ☐	Skin problems	No ☐	Yes ☐
Cancer	No ☐	Yes ☐	Stomach Ulcers or Swallowing Problems	No ☐	Yes ☐
Chicken Pox	No ☐	Yes ☐	Thyroid Problems	No ☐	Yes ☐
Clotting Problems - Bleed too much or History of Blood Clots	No ☐	Yes ☐	Tuberculosis or Positive TB Test	No ☐	Yes ☐
Developmental or Behavioral Disorders	No ☐	Yes ☐	Vision or Eye Problems	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐	Other:	No ☐	Yes ☐
Domestic Violence	No ☐	Yes ☐		No ☐	Yes ☐
Ear Infections - Chronic	No ☐	Yes ☐		No ☐	Yes ☐
Ear or Hearing Problems	No ☐	Yes ☐		No ☐	Yes ☐
Eczema	No ☐	Yes ☐		No ☐	Yes ☐

Does anyone smoke at home? NO YES **Who?**_____

Parents' Marital Status? _____

What is child's current living arrangement?
House Apartment Foster Care Home Other (specify) _____

Who does child live with? (Circle all that apply) Mother Father Step-Parent Grandparent Aunt/Uncle

Foster Family Sibling(s) Other _____

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Name: (page 3)_____

Prenatal and Birth History

Did this child's mother receive prenatal care? NO YES

Any maternal illness/complications/infections during pregnancy? NO YES_____

Gestational age at birth: _____ weeks

Type of delivery: Vaginal Planned C/S Unplanned C/S Forceps/Vacuum

Reason for unplanned C/S _____

Birth Weight: _____ lbs _____ oz Any complications with delivery? NO YES

Any complications with your child post partum? NO YES_____

Days your child spent in hospital: _____ days

Hearing test: PASSED FAILED UNKNOWN

Nutrition

Was your child breast fed? NO YES If yes, for how long? _____

Any special dietary needs (i.e. Gluten Free)? NO YES _____

Safety

Is your home "child proofed"? NO YES

Type of car seat your child uses: 5-point harness Rear facing Forward Facing Booster

Does your child use helmet for bike/scooter? NO YES

Is there anyone in the house who uses recreational drugs? NO YES

Does your home environment feel safe? NO YES

Do you feel like you need/want help with parenting skills? NO YES

Do you have concerns about meeting basic needs (food/clothing/shelter?) NO YES

Other Questions

Does your child attend Day Care or Preschool? NO YES

Do you feel your child is developing at the same rate as other children? NO YES DON'T KNOW

Do you feel your child interacts normally (like other children) with others? NO YES DON'T KNOW

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Name: (page 4)_____

Family Health History

Is your child adopted? Yes / No (If NO, please complete section below)

	Father	Mother	Grandmother	Grandfather	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety or Depression								
Arthritis								
Asthma								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Manic-Depression or Bipolar								
Migraines								
MI = Heart Attack								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

Thank you!