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Pediatric New Patient Health History – 6-11 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/Hay fever	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

Gestational age at birth: _____ weeks

Any complications with delivery? NO YES

Any complications with your child postpartum? NO YES_____

Days your child spent in hospital: _____ days

Nutrition

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

Safety

Type of car restraint your child uses: Booster Seat Belt Only None

Does your child use a 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

Education and Activity

Grade in School _____ Name of School_____

School Performance: At Grade Level Above Grade Level Needs Assistance

Sports? Yes / No _____ Hobbies? Yes / No _____

Any problems with Bullying? Yes / No

Screen Time (TV/Computer/Phone) Daily (on average)?

None Less than one hour 1-2 hours 3 hours or more

How much time does this child spend outside each day (on average)?

None A few minutes One hour daily More than one hour daily

Does this child struggle with anxiety or depressed moods?

NO YES MAYBE

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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!