



Child Health History - New Patient

Name: _____ Date of Birth: _____ Today's date: _____

Form updated: _____

Name / birthday of parents and siblings:

Parents: (Father): _____ — / / (Mother): _____ — / /
DOB DOB

Siblings: _____ — / / _____ — / /
DOB DOB

_____ — / / _____ — / /
DOB DOB

Pregnancy and Birth History

While pregnant, did patient's mother:

If yes, please explain

Have any medical problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Need any special tests	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Take any medicines	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Get sick	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Use tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Use alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have problems with labor or delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Any health problems after birth for baby?: _____

Pregnancy Length (weeks)? _____ Birth Weight? _____ How many days was your baby in the hospital after birth: _____

Family History - has anyone in the immediate family had:

If yes, who had this?

If yes, who had this?

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		SIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sudden unexplained death	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other mental health issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sickle cell anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No		Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hip problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		GI (gut) problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		Birth defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deafness/hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		Any other major medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No				

PHYSICIAN USE ONLY - Genogram (family tree)

Child Medical History

Has your child had any of the following:

If yes, please explain

Chicken Pox?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Does your child take any prescription medications?

Yes No

Please list: _____

Has your child had problems with any of the following:

If yes, please explain

Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing or Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ear Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart problems / murmurs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
GI (gut) problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney or bladder infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental health issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Significant injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other major problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list past medical providers for your child: _____

Child Development - How old was your child when he or she:

First smiled	
Sat alone	
Walked	
First talked	
Used sentences	
Toilet trained	

Do you have any concerns about your child's development: Yes No

If yes, please explain _____

If your child is in school, how is he or she doing? _____

Home Environment:

Who lives with your child at home: _____

Does anyone smoke at home: _____

Are there any pets at home: _____

When was your house built: _____

Is your child in day care: _____