New Patient History

Today's Date________________

Child's Name:________________________ **DOB**__________ **Gender:** M F

Allergies to Medications ________________ Routine Medications:____________

Family History (Please write in affected family member on blank)

ADHD________________________ Hypertension________________________

Allergies________________________ Immune system problems________________

Anemia________________________ Kidney Disease________________________

Asthma________________________ Malignancies (cancer)________________

Depression________________________ Mental Illness ________________________

Developmental Issues________________ Migraines________________________

Diabetes________________________ Seizures________________________

Heart Disease ________________________ Substance Abuse________________

High Cholesterol________________ Tuberculosis________________________

Social History

Diet: Regular, Vegetarian, Vegan, Gluten Free, Diary Free Other________________

Parents Marital Status: Married, Never Married, Separated, Divorced, Widowed

Child Lives With? Parents Mom Dad Relative Foster Parent Other____________

Siblings Names and Ages____

Child Care? Yes No: Relative Sitter/Nanny Day Care/School

Pets at Home? Yes No Type________________

Passive Smoke Exposure? Yes No Who:________________

Smoke and CO detectors? Yes No

Seat belts/car seats? Yes No

Sunscreen used routinely? Yes No

Guns in Home? Yes No Locked? Yes No

Child's school and grade if applicable: ________________________________

Pool Exposure? Yes No

Bike Helmet? Yes No

Any other issues at home or school you would like to discuss?________________

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