



PATIENT HISTORY FORM

Person Completing Form: _____ Date Form Completed: _____

Child's Name: _____ DOB: _____

If we need to teach you something relating to your child's health, would you prefer for us to: (Check all that apply)

- give you written information
- tell you the information
- show you how to do something new

Do you (as a parent/guardian) have any problems that would affect your understand

None Illness Speech Vision Able to read

Difficulty reading Unable to read Emotional Physical

My primary language is: English Spanish Other _____

Child's History:

Describe Your Child's Health: _____

Birth Weight: _____ Complications at Birth? _____

Current Medications: _____

Drug Allergies: _____

Hospitalizations and Surgery: _____

Extended Illnesses: _____

Significant Injuries: _____

Chicken Pox? Yes No

Immunizations Current? Yes No

Describe Your Child's Growth: _____

Describe Your Child's Development: _____

Describe the Temperament of Your Child: _____

Current School: _____ Current Grade _____

Educational and Academic History: _____

Review of Systems

Please check if your child has any problems in the following body systems:

- | Problems | No Problems |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Constitutional (Chronic pain, unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol) |
| <input type="checkbox"/> | <input type="checkbox"/> Eyes (Cataracts, Cross Eyes) |
| <input type="checkbox"/> | <input type="checkbox"/> Ears, Nose, Mouth and Throat (Chronic Ear or Sinus Infections) |
| <input type="checkbox"/> | <input type="checkbox"/> Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack) |
| <input type="checkbox"/> | <input type="checkbox"/> Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease) |
| <input type="checkbox"/> | <input type="checkbox"/> Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems) |
| <input type="checkbox"/> | <input type="checkbox"/> Joints, Muscles, Extremities |
| <input type="checkbox"/> | <input type="checkbox"/> Skin |
| <input type="checkbox"/> | <input type="checkbox"/> Neurological System (ADHD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's) |
| <input type="checkbox"/> | <input type="checkbox"/> Psychological or Mental Health (Depression or Anxiety) |
| <input type="checkbox"/> | <input type="checkbox"/> Endocrine (Glandular Problems, Diabetes, Thyroid Disease) |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disease (SCA, Sickle Trait) |
| <input type="checkbox"/> | <input type="checkbox"/> Immunology (Chronic Allergies, Weak Immune System) |
| <input type="checkbox"/> | <input type="checkbox"/> Bladder & Kidney (Chronic Bladder Infections, Kidney Failure) |

First Time Provider Reviewed: _____ Date: _____

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Child's Name: _____ DOB: _____

Social History:

Mother's Name: _____ Occupation _____ DOB _____

Father's Name: _____ Occupation _____ DOB _____

Siblings: Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Marital Status of parents: _____

Child lives with: _____

Are there any family circumstances we should know about? _____

Smokers in house? Yes No Who? _____

Firearms in house? Yes No _____

Smoke detectors in the house? Yes No _____

Pets (Describe): _____

Religious Preference: _____

Family History:

Please describe any health conditions in your family. Please include the child's parents, brothers, sisters, grandparents (maternal and paternal), aunts and uncles. (check the condition and identify who has the condition in the blank space to the right).

Problems	No Problems	Who	What
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional _____	_____
		(Chronic pain, unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol)	
<input type="checkbox"/>	<input type="checkbox"/>	Eyes _____	_____
		(Cataracts, Cross Eyes)	
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth and Throat _____	_____
		(Chronic Ear or Sinus Infections)	
<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels _____	_____
		(Hole in Heart, Murmur, High Blood Pressure, Heart Attack)	
<input type="checkbox"/>	<input type="checkbox"/>	Breathing or Lung Disease _____	_____
		(Asthma, Bronchitis, CF, other lung disease)	
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, Intestinal Tract _____	_____
		(Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)	
<input type="checkbox"/>	<input type="checkbox"/>	Joints, Muscles, Extremities _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological System _____	_____
		(ADHD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)	
<input type="checkbox"/>	<input type="checkbox"/>	Psychological or Mental Health _____	_____
		(Depression or Anxiety)	
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine _____	_____
		(Glandular Problems, Diabetes, Thyroid Disease)	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease _____	_____
		(SCA, Sickle Trait)	
<input type="checkbox"/>	<input type="checkbox"/>	Immunology _____	_____
		(Chronic Allergies, Weak Immune System)	
<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Kidney _____	_____
		(Chronic Bladder Infections, Kidney Failure)	

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