The CHILDREN'S HEALTH PLACE

4-10 years old

NEW PATIENT HEALTH HISTORY FORM

Patient First Name:_____Patient Last Name:_____

Patient DOB_____Age_____Male/Female

SOCIAL HISTORY

Parent Name:_____Parent Name:_____

Mother's Occupation:_____Father's Occupation:_____

Is the child yours by: ◯ Birth ◯ Step Child ◯ Foster ◯ Adoption ◯ Other

Child's parents are: ◯ Married ◯ Divorced ◯ Unmarried ◯ Other

Who lives in the child's household? ◯ Mom ◯ Dad ◯ Step parent ◯ Grandparent ◯ Siblings #_____ ◯ Other

Childcare: ◯ Stay at home parent ◯ Nanny/ Babysitter ◯ Relative ◯ Daycare Name of daycare:_____

◯ School Grade:_____

Name of School:_____

Do any family members in the child's household smoke, vape, or use e-cigarettes? YES NO

PREGNANCY & NEONATAL PERIOD

Which hospital was your child born at?_____City, State:_____

Birth Weight:_____ Birth Length:_____

Delivery by: Vaginal OR C-Section If C-section, please explain reason:_____

Was your child premature? NO YES, born at _____weeks NICU stay? YES NO

Were there any other problems during your pregnancy or newborn period?_____

DEVELOPMENT & NUTRITION

How many hours per day does your child (outside of school):			
Watch TV		Play video games	
Exercise/Play outside		Use computer/tablet	

Does your child have a regular bedtime? YES NO

What time? _____

Does your child have caffeine? YES NO

If yes, approximately how much per day?

_____

Does your child have any dietary restrictions? YES NO

If yes, please explain? _____

Would your family like to receive assistance or resources regarding:

Food security Housing Transportation Education/School Behavioral Health/Mental Health Services for child or parent/guardian

PATIENT HEALTH HISTORY

Has your child ever been treated for or diagnosed with: If yes, please explain

- ○ Asthma/reactive airway/wheezing_____
- ○ Seasonal allergies or eczema_____
- ○ Food or drug allergy_____
- ○ Recurrent ear infection. How many_____
- ○ Pneumonia_____
- ○ Urinary Tract Infection (UTI)_____
- ○ Genetic syndrome_____
- ○ Seizures_____
- ○ Anemia_____
- ○ Broken bone_____
- ○ Developmental delay/learning disability_____
- ○ Mental health/behavioral concerns_____
- ○ Poor weight gain_____
- ○ Concussion. How many_____
- ○ Acid reflux_____
- ○ Constipation_____
- ○ Cancer/Blood disorders_____
- ○ Other medical conditions_____

Any surgeries/procedures?_____

MEDICATIONS & ALLERGIES

Any allergies to medications? If yes, please list and describe the reaction:_____

Current medications & dose:_____

List any vitamins, supplements, or over-the-counter meds:_____

PATIENT FAMILY HISTORY

(MGM/MGF=Maternal Grandparent | PGM/PGF=Praternal Grandparent)

Do any family member have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent (if grandparent, which one?)
Asthma	○	○	○	○ MGM MGF PGM PGF
Anemia	○	○	○	○ MGM MGF PGM PGF
Blood Disorder	○	○	○	○ MGM MGF PGM PGF
Cancer	○	○	○	○ MGM MGF PGM PGF
Heart attack/disease	○	○	○	○ MGM MGF PGM PGF
High cholesterol	○	○	○	○ MGM MGF PGM PGF
High blood pressure	○	○	○	○ MGM MGF PGM PGF
Stroke	○	○	○	○ MGM MGF PGM PGF
Diabetes	○	○	○	○ MGM MGF PGM PGF
Thyroid disease	○	○	○	○ MGM MGF PGM PGF
Kidney disease	○	○	○	○ MGM MGF PGM PGF
Seizures	○	○	○	○ MGM MGF PGM PGF
Migraines	○	○	○	○ MGM MGF PGM PGF
Depression/anxiety	○	○	○	○ MGM MGF PGM PGF
Alcoholism	○	○	○	○ MGM MGF PGM PGF
ADHD	○	○	○	○ MGM MGF PGM PGF
Adverse reaction to anesthesia	○	○	○	○ MGM MGF PGM PGF

Please explain all positives: _____

Other, please explain:_____