The CHILDREN'S HEALTH PLACE

Newborn-3 years

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:_____

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:_____

Time of birth:_____AM/PM Birth Weight:_____ Birth Length:_____

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

Was your child premature (<37 weeks)? NO YES, born at _____weeks . NICU stay? YES NO, If yes, how long?_____

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

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:_____

DEVELOPMENT & NUTRITION

At what age did your child:			
Walk alone		Say words	
Sit alone without support		Toilet train	

Is/was your child breastfed? YES NO

If yes, how long? _____

Is your child using formula? YES NO

If yes, what type & brand? _____

_____

Does your child have any unusual feeding or dietary problems? YES NO

If yes, please explain? _____

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 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_____Most recent_____
- ◯ Acid reflux_____
- ◯ Constipation_____
- ◯ Cancer/Blood disorders_____
- ◯ Other medical conditions_____

Any surgeries/procedures?_____

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:_____

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