Health History Form

Today's Date _____

Patient's Name: First_____ Middle _____ Last _____ Suffix ___

Date of birth: _____ Age: _____ Sex: M F Race (optional) _____

Prenatal / Birth History

Complications of pregnancy:_____

Birth Location: _____ Gestational Age: _____ wks Delivery: □ Vaginal □ Forceps □ C-section

Complications: _____ Birth Weight: _____ Birth Length: _____

Current or Chronic Health Problems

Please list any current health concerns: _____

_____ _____

_____ _____

Past Medical History

Childhood Illnesses:

Acne	Y	N	Allergies	Y	N	Croup	Y	N	Pneumonia	Y	N
ADD	Y	N	Bedwetting	Y	N	Diabetes	Y	N	Sickle cell disease	Y	N
Allergies	Y	N	Behavior problem	Y	N	Ear Infections	Y	N	Sinus infections	Y	N
Anemia	Y	N	Blood Disorder	Y	N	Heart problem	Y	N	Sleep apnea	Y	N
Anorexia	Y	N	Chronic diarrhea	Y	N	Heartburn/Reflux	Y	N	Thyroid disease	Y	N
Arthritis	Y	N	Colic	Y	N	Kidney stones	Y	N	Tonsillitis	Y	N
Asthma	Y	N	Constipation	Y	N	Lung disease	Y	N	Urinary infection	Y	N

Other serious or chronic health conditions: _____

_____

Hospitalizations:_____ Surgeries:_____

_____ _____

Serious Injuries:_____ Reactions to anesthesia:_____

Do you have any developmental concerns about your child? _____

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Medication History

Medication Allergies:

Name of medicine: _____Type of reaction:_____

Name of medicine: _____Type of reaction:_____

Other allergies: _____

Medications: (Please list any prescription or over the counter medications that the patient is currently taking with dosages)

_____ _____

_____ _____

Supplements / Homeopathic remedies / Vitamins: _____

_____ _____

Immunization History

	Date	Date	Date	Date	Date	Date
DaPT						
Polio						
Hep B						
HiB						
Pneumococcus						
Rotavirus						
Influenza						
MMR						
Chicken pox						
Hepatitis A						
TDaP						
Meningococcus						
HPV						
Typhoid						
Rabies						
BCG						

(You may attach a printout of your child's vaccine record if available)

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Family History

Please circle all that apply:

Problem:	Relation to patient:	Problem:	Relation to patient:	Problem:	Relation to patient:
Allergies		Eczema		Metabolic disorders	
Anemia		Gastric ulcers		Neurologic disease	
Arthritis		Heart disease		Psychiatric disorders	
Asthma		Hypertension		Renal disorders	
Blood disorders		Kidney stones		Skin disorders	
Bone disorders		Liver disease		Stroke	
Cancer		Lung disease		Thyroid	
Diabetes					

Social History

Please list all individuals who live in the household and their relation to patient. For siblings please also list their age(s):

Name	Relation to patient	Name	Relation to patient

If additional space is needed, please record on back

Social History (cont.)

Birth parents: Married? □ Divorced? □ Mother deceased? □ Father deceased? □

Patient currently lives with: Birth mother □ Birth father □ Step mother □ Step father □ Foster parents □

Does anyone in the household smoke? Y N

Does the patient attend day care (or other settings with multiple young children)? Y N

Does the patient attend school? Y N If yes, name of school _____

Does the patient live in the city? Y N Outside of the city? Y N Rural setting? Y N

Is the house that the patient live in more than 30 years old? Y N

City water supply? Y N Well water? Y N

Has the patient been to a foreign country? If so, which one(s)?_____

If you would like to transfer records from any previous health care provider, please ask the receptionist for a record release form.