PEDIATRIC

New Patient Health History Questionnaire

Patient's Name: _____ Date of Birth: _____

Primary Language: _____ Race/ethnicity: _____

Gender: _____

Patient's Previous Doctor (Name, City, State): _____

Person completing this form: Name _____, relationship to patient _____

Highest Level of Education for person completing form:

☐ Less than High School (Grade ___)

☐ High School Diploma/GED ☐ Trade School

☐ Some College/Associates ☐ Bachelors, Masters, or Graduate School

How confident are you in filling out forms by yourself? ☐ Extremely ☐ Quite a bit

☐ Somewhat ☐ A little bit ☐ Not at all

Is the patient adopted or fostered? Yes No Other _____

Name all persons living in the patient's home at this time:

Name	Age	Relationship

Were there any significant complications during pregnancy or delivery? Please list below.

_____

☐ No significant complications.

During the pregnancy, did the patient's mother [ ] smoke, [ ] drink alcohol or take drugs,

[ ] have any illness (if so, please list _____) ?

Birth Weight _____ Was patient born premature? ☐ Yes ☐ No

If so, by how many weeks? _____

Past/Present Medical History: Please list any previously diagnosed medical illnesses. For example: learning or developmental problems, congenital defects, asthma, eczema/skin issues, depression/anxiety, cancer, heart problems, kidney disease, seizures, blood disorders, etc.

_____

_____

_____

☐ No history of significant medical illness.

Allergies: Please list all allergies and types of reactions. ☐ No allergies.

Allergy:	**Reaction:**

Family History: Please check all that apply.

☐ Adopted/Fostered - family history unknown. ☐ No significant family history.

	Alcohol/Drug Abuse	**Asthma**	**Cancer (type:_____) Age of diagnosis ___**	**COPD**	**Depression/ Anxiety**	**Bipolar**	**Diabetes Age of diagnosis ___**	**Heart Disease Age of diagnosis ___**	**High Blood Pressure Age of diagnosis ___**	**Kidney Disease**	**Obesity**	**Stroke Age of diagnosis ___**	**Thyroid Disease**	**Migraines**	**Deceased Cause of death _____**
Mother															
Father															
Brother															
Sister															

Please list any other significant family history below (including autoimmune diseases, genetic disorders, and blood disorders):

_____

_____

_____

Social History: Please check all that apply.

	YES	**NO**
Is your child exposed to secondhand smoke (inside or outside)?		
Are there working smoke detectors in the child's home?		
Are there guns in the home?		
If so, are they locked in a safe?		
Does your child ALWAYS wear a seat belt in the car?		

Medications: Please list ALL of your child's medications (including over the counter medications, vitamins, and supplements).

Medication Name:	**Medication Strength (Dosage):**	**How Often Medication is Taken (Frequency):**

Surgical History: Please list all past surgeries or medical procedures and dates below.

Surgery/Procedure:	**Date:**

Growth and Development:

Do you have any concerns about your child's growth or development (speech, language, social skills, motor skills, etc)? If yes, please explain:

_____

_____

Does the patient have difficulty in school with [ ] learning, [ ] behavior, [ ] other _____?

☐ No difficulties with school.

Other Providers/Specialists: Please list any other providers or specialists that your child sees regularly below.

_____

_____

_____

I would like to discuss the following concerns…

_____

_____