Pediatric and Adolescent Medicine
New Patient Health History

Today's Date: ___/___/___
Primary Pediatrician: _____
Birth Date: ___/___/___
Patient's Full Name: _____ ☐ male ☐ female ☐ other
Patient's Nickname: _____ Preferred Pronouns: _____
Name of person completing this form: _____ Relationship to patient: _____

Please list patient's current medical diagnoses: ☐None

Please list all medicines/vitamins/supplements:☐None

Please list any medicine/food/latex allergies: ☐None

This patient has : *(include details)*

-been in a hospital overnight? ☐Y

-gone to the emergency room? ☐Y

-gone to an urgent care center? ☐Y

-had an allergic reaction? (medication, food, insect) ☐Y

-had surgery? (an operation) ☐Y

-seen a medical specialist or doctor elsewhere? ☐Y

-traveled outside of the U.S.? ☐Y

Today I have concerns about:

Headaches/Head Injury?..... ☐Y
Vision/Hearing?..... ☐Y
Dental? ..... *(Brushes?* ☐Y ☐ N*, Sees dentist?* ☐Y☐ N*)* ..... ☐Y
Ears/Eyes/Nose/Throat? ..... ☐Y
Allergies?..... ☐Y
Cough/Wheeze/Trouble breathing? ..... ☐Y
Chest pain?..... ☐Y
Abdominal pain?..... ☐Y
Stools or Urination?..... ☐Y
Genitals?..... ☐Y
Muscles/Joints/Bones?..... ☐Y
Skin?..... ☐Y
Abnormal Bleeding or Bruising?..... ☐Y
Sleep?...*(at least 10-12h preschool, 10h 5-12y, 9-10h teens)*..... ☐Y
Development?..... ☐Y
Behavior/Mental Health?..... ☐Y
Learning/School Performance?..... ☐Y
Nutrition?..... ☐Y
Weight/Growth?..... ☐Y
Substance use/abuse?..... ☐Y
Sexual activity?..... ☐Y
Other? *(Include details)*..... ☐Y

For girls: Has she started her period? ☐N ☐Y, at age _____
If yes, when did the last period start? ___/___/___
Is she having any problems? ☐N ☐Y:

	Parent/Guardian #1	Parent/Guardian #2
Name:		
Preferred contact #:		
Occupation:		

Parents are: ☐Married ☐Divorced ☐Separated ☐Single ☐Other:
Child lives with: ☐Both parents ☐Other: _____
☐Parent #1_____% (☐*remarried*) ☐Parent #2_____% (☐*remarried*)
Others in the home: *(name/age/relationship)*

Recent family changes or stress? ☐ N ☐Y:

In the last year did you worry about or run out of food and not have enough money to buy more? ☐ N ☐Y

Patient attends:
☐**Daycare** ☐**Sitter** ____ days/week at _____
☐**Preschool** ____ days/week at _____
☐**School**, in Grade:____ at _____
---Child's school performance/grades/GPA: _____
Does your child receive any special services? ☐N ☐Y
☐IEP ☐504 ☐Gifted ☐Therapy ☐Other:

Patient's sports/activities/hobbies:

Concerns about relationships w/ friends, family, others? ☐N ☐Y

Home Environment/Safety: What year was your home built? _____
☐House ☐Apartment ☐Condo ☐Trailer ☐Other:
Are there: Carbon monoxide detectors? ☐Y
----------Smoke detectors? ☐Y
----------Fire extinguishers? ☐Y
----------Pool? ☐Y Locked? _____How? _____
--Pets/Animals? ☐Y What kind? _____
---------Firearms? ☐Y How are they stored?_____
---------Smokers? ☐Y Who smokes? _____ Where? _____

Does your child: -wear a helmet appropriately? ☐Y
-use sunscreen appropriately *(SPF 15 or above)*? ☐Y
-know how to swim *(or take lessons if 4 or older)*? ☐Y

When riding in a car, my child uses:
☐Rear-facing car seat *(<2y)*
☐Front-facing car seat *(until weight exceeds seat specifications)*
☐Booster *(belt positioning booster seat until 4'9")*
☐Seat Belt in back seat ☐Seat belt in front seat *(>12y)*

(Please complete other side)

Patient Name: _____ DOB: _____/_____/_____ Today's Date: _____/_____/_____

Please record your child's Family Medical History below.

☐ I previously completed a Family History for this patient:
☐ No changes since. *(You may stop here.)* ☐ New information added below.

☐ I have multiple children here TODAY and have completed this TODAY on the form of child: _____

☐ Patient adopted; No **Biologic** Family History available.

☐ Patient adopted; Limited **Biologic** Family History recorded below.

☐ Patient conceived by IVF with donor ☐Egg ☐Sperm (only include details of blood relatives below)

Have any blood relatives of THIS PATIENT had these conditions (parents, siblings, grandparents, aunts, uncles)?
Please include details for all YES answers, including which relatives and whether on father's or mother's side.

ADD/ADHD…….. ☐ Y:
Alcoholism …….. ☐ Y:
Allergies…….. ☐ Y:
Asthma…….. ☐ Y:
Birth Defects…….. ☐ Y:
Blood/Bleeding disorders…….. ☐ Y:
Bowel Disease…….. ☐ Y:
(Ulcerative colitis, Crohn's, Irritable Bowel)
Cancer (*include type*) …….. ☐ Y:
Deafness…….. ☐ Y:
Depression…….. ☐ Y:
Developmental delays…….. ☐ Y:
Diabetes (*Type 1 or Type 2?*)…….. ☐ Y:
Early death/SIDS…….. ☐ Y:
Eczema…….. ☐ Y:
Family or inherited diseases…….. ☐ Y:
Heart attack before age 55…….. ☐ Y:
Heart disease…….. ☐ Y:
High cholesterol/lipids/triglycerides……. ☐ Y:
High blood pressure…….. ☐ Y:
Hip dysplasia…….. ☐ Y:
Immune disorders…….. ☐ Y:
Kidney Disease…….. ☐ Y:
Learning Disability…….. ☐ Y:
Liver Disease…….. ☐ Y:
Lung Disease…….. ☐ Y:
Mental Health *(Anxiety, Bipolar, Depression, etc.)* ☐ Y:
Mental Retardation…….. ☐ Y:
Metabolic Disorders…….. ☐ Y:
Migraines…….. ☐ Y:
Neurologic disease…….. ☐ Y:
Obesity…….. ☐ Y:
Scoliosis…….. ☐ Y:
Seizures/Epilepsy…….. ☐ Y:
Serious or fatal childhood illness…….. ☐ Y:
Strabismus ("Lazy eye") …….. ☐ Y:
Substance abuse…….. ☐ Y:
Thyroid disease…….. ☐ Y:
Tuberculosis…….. ☐ Y:
Other…….. ☐ Y:

Thank you for completing this information.