NEW PATIENT MEDICAL HISTORY - 6 MONTHS OLD & OVER

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE OR DURING 1st VISIT

The following is **very important** to your child's health. Please complete it **accurately** and completely.

Child's name: _____ Birth date: _____/_____/_____

Where was your child born?_____ Is child adopted or fostered? **Y N**

BIRTH HISTORY			
Birth Weight: lbs. oz. Vaginal birth? C-section?			
Was the baby: (circle one) Full term Early Late			
If early, how many weeks gestation?			
Did the baby have any problems right after birth?			
Did mother have any problems with the pregnancy?			
DEVELOPMENTAL HISTORY	**No**	**Yes**	If Yes - explain
Are you concerned about your child's physical development?			
Are you concerned about your child's attention span?			
Has he/she failed or repeated a grade?			
How is your child's behavior in school?			
What kind of grades does he/she make in academic subjects?			
Is he/she in a special or resource classes?			
PATIENT ALLERGIES			
List any allergies your child has including medication, food, and environmental.			
PATIENT SOCIAL HISTORY	**No**	**Yes**	
Does patient live with both mother and father in the same house?			
Are there siblings?			
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunitions?			

PATIENT - PAST MEDICAL HISTORY	Give Details
Serious accidents or injuries	
Surgeries	
Hospitalizations	
Chicken Pox Disease	What age:
Frequent ear infections or sinus infections	
Frequent sore throats or tonsillitis	
Allergic rhinitis or other allergy	
Asthma, bronchitis, bronchiolitis, pneumonia or croup	
Heart problems or heart murmur	
Abdominal pain/reflux	
Constipation requiring doctor visits	
Bladder or kidney infection or other urologic problem	
Bed-wetting (after age 6)	
Eye conditions / wear corrective lenses	
Problems with ears or hearing	
Chronic or recurrent skin problems / acne	
Anemia or bleeding problem	
Frequent headaches	
Convulsions, seizures, or past concussions?	
Seizures, developmental delays, ADD/ADHD or other neurological disorders	
Orthopedic problems	
Diabetes	
Thyroid, diabetes or other endocrine problems	
If female, have menstrual periods started?	
If female, any problems with periods?	
Use of alcohol or drugs	
Emotional or mental health problems	
Other significant issues:	
Current Medications and Dosage: (include any over the counter, herbal, or supplements)	
Does your child see any specialists? If so, who and where?	

I attest that all the medical history information is true and correct to the best of my knowledge:

Print Name _____ Relationship to Patient _____

Signature _____ Today's Date _____/_____/_____