Patient Name: _____ **DOB:** _____

Patient's Family Medical History

Is the patient adopted? ___Yes ___No

Conceived via ___Sperm Donation ___Egg Donation ___ Surrogacy?

Is the child's family history known? ___Yes ___No

Please circle that the realative the information is regarding: mom or dad, then maternal (mom) or paternal (dad) grandparent	Parent: Mom or Dad	Parent: Mom or Dad	Grandma Mat. or Pat.	Grandpa Mat. or Pat.	Grandma Mat. or Pat.	Grandpa Mat. or Pat.	Siblings
List here if the blood relative is alive (A) or deceased (D)							
High Blood Pressure							
Allergies, Hay Fever							
Diabetes							
Heart Disease ie, Heart Attack, Stroke (please specify)							
High Cholesterol							
Tuberculosis							
Depression							
Anxiety							
Mental Health Disorder (please specify)							
Neurologic Disorders (please specify)							
Alzheimer's Disease							
Parkinson's Disease							
Asthma							
Anemia							
Arthritis/Joint Disorder							
Bleeding Disorder							
Cancer (please list type for each person)							
Hearing Loss							
Skin Problems							
Kidney Disease							
Thyroid Problems							
Stomach/Bowel Problems							
Vision Problems (please specify)							
Reactions to Anesthesia							
Alcohol Abuse							
Drug Abuse							
Smoking							

LIVING SITUATION *If there is additional information you'd like to share please use the back of this form.*

How many people live in your household? ____ # of Adults ____ # of Children

Names of all people in your household: _____

Relationship of parents/guardians: ___ Married ___ Partnered ___ Divorced ___ Separated ___ Single ___ Widowed ___ Other

If divorced, separated, or single, is the other parent involved? ___ Yes ___ No

Does the child regularly live in another household? ___ No ___ Yes If yes, describe _____

Does anyone who lives where the child stays smoke or have significant health issues? _____

PREVIOUS HEALTH HISTORY FOR YOUR CHILD (has your child had any of the following)

Is your child enrolled in special services for: ____ Speech ____ Behavior ____ Learning

Trauma/Fractures _____

Chronic or recurrent problems with: ____ Ear Infections ____ Asthma/Wheezing ____ Bladder infections ____Mental Health

Any Hospitalizations? ____ No ____ Yes If yes, age(s) _____ Reason _____

Any surgeries? ____ No ____ Yes If yes, age(s) _____ Type of Surgery_____

Any allergies? ____No ____ Yes If yes, describe _____

Updated - Date _____ Initials _____ Updated - Date _____ Initials _____

Updated - Date _____ Initials _____ Updated - Date _____ Initials _____

NEWBORN HISTORY

Patient's Name_____ DOB_____

(If patient is greater than 2 years of age, skip to side 2)

Please fill in or check off each item.
This information will help us provide your child with quality medical care.

Newborn History (Full term = 40 weeks)

How many weeks gestation? _____
Birth weight? _____
Hepatitis B shot at hospital? ☐ Yes ☐ No
Which pregnancy was this for mom? _____
How many living children? _____
Mom's age at baby's birth? _____
What hospital was the baby born at? _____

Baby's Delivery

Vaginal _____
C-Section _____
Induced _____
Spontaneous _____

	Yes	No	Unsure
Did the baby have any problems at birth?	☐	☐	☐
Time in the intensive care nursery?	☐	☐	☐
Jaundice, high bilirubin?	☐	☐	☐
Need bili-lights?	☐	☐	☐
Infections?	☐	☐	☐
Medications?	☐	☐	☐
Were there any complications with the pregnancy, labor, delivery or birth?	☐	☐	☐

Please fill in if you had the following during your pregnancy with this child:

	1st 3 months	2nd 3 months	3rd 3 months
Infections - Cold, Flu - Chlamydia, Gonorrhea, etc. - Bladder Infections			
Medications (other than vitamins)			
Accidents or Injuries - Did anyone hurt you?			
Smoking - How many packs/day?			
Alcohol (Includes beer, wine, other) - Include type of alcohol - How often you drank - Amounts you drank - Include amounts during time you did not know you were pregnant			
Drugs - Include type and how often			