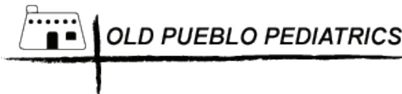

PATIENT HEALTH HISTORY – PAGE 1 OF 2

NAME: ______________________________ DATE OF BIRTH: ______________

SEX: ____ RACE: ____________ SOCIAL SECURITY NO.: ________________

Please list all people in household:

FATHER: ________________ DOB: ________ OCCUPATION: ____________

MOTHER: ________________ DOB: ________ OCCUPATION: ____________

OTHER: ________________ DOB: ________ OCCUPATION: ____________

OTHER: ________________ DOB: ________ OCCUPATION: ____________

OTHER: ________________ DOB: ________ OCCUPATION: ____________

Have there been any recent major changes or stresses in the child's life? ________ No ________ Yes

If YES, please explain: ____

Does the child go to a babysitter, preschool, or daycare regularly? ________ No ________ Yes

BIRTH HISTORY

Birth Weight: ________ Length: ________ Place: ______________________

During the pregnancy, did the mother see a doctor regularly? ________ No ________ Yes

During the pregnancy, did the mother: (If YES, explain):

Have any medical problems? ________ No ________ Yes ____________

Smoke, consume alcohol or drugs? ________ No ________ Yes ____________

Use any medications? ________ No ________ Yes ____________

Have problems with labor/delivery? ________ No ________ Yes ____________

How long did the baby stay in the hospital after birth? ______________________

PAST MEDICAL HISTORY

Is the child's general health: (check one) ________ Good ________ Fair ________ Poor

Does the child have any allergies? (If YES, explain): ________ No ________ Yes ________

Has the child had any bad reactions to medication? (If YES, explain): ________ No ________ Yes

____

Is the child taking any medications? (If YES, explain): ________ No ________ Yes

____

Please list any hospitalizations, operations, serious illnesses or accidents, with dates:

____ Date: __________

____ Date: __________

____ Date: __________

PATIENT HEALTH HISTORY – PAGE 2 OF 2

Has the child ever had any problems with the following: (If YES, please explain):

Eyes/Vision	_____ No	_____ Yes	____________________
Nose/Throat	_____ No	_____ Yes	____________________
Digestion/Nutrition	_____ No	_____ Yes	____________________
Ears/Hearing	_____ No	_____ Yes	____________________
Urine/Kidneys	_____ No	_____ Yes	____________________
Joints	_____ No	_____ Yes	____________________
Skin	_____ No	_____ Yes	____________________
Lungs	_____ No	_____ Yes	____________________
Teeth	_____ No	_____ Yes	____________________
Heart	_____ No	_____ Yes	____________________
Seizures	_____ No	_____ Yes	____________________
Repeated Infections	_____ No	_____ Yes	____________________

FAMILY HISTORY

Have any of the child's brothers or sisters died? _____ No _____ Yes
(If YES, give age and cause): ____________________

Have any of the child's blood relatives had the following diseases? (If YES, please list family member):

Heart Disease	_____ No	_____ Yes	____________________
Tuberculosis	_____ No	_____ Yes	____________________
High Blood Pressure	_____ No	_____ Yes	____________________
Kidney Disease	_____ No	_____ Yes	____________________
Allergies/Asthma	_____ No	_____ Yes	____________________
Cancer	_____ No	_____ Yes	____________________
Diabetes	_____ No	_____ Yes	____________________
Mental/ Emotional Problems	_____ No	_____ Yes	____________________
Sickle Cell Anemia	_____ No	_____ Yes	____________________
Seizures	_____ No	_____ Yes	____________________

DEVELOPMENT

Do you have any concerns about the following?

Development	_____ No	_____ Yes	____________________
Behavior	_____ No	_____ Yes	____________________
Eating Habits	_____ No	_____ Yes	____________________
School Experience	_____ No	_____ Yes	____________________
Bathroom/ Toilet Habits	_____ No	_____ Yes	____________________
Discipline	_____ No	_____ Yes	____________________
Other (Explain)	_____ No	_____ Yes	____________________

Signature: ____________________ Date: ____________________