

Name: _____

Date: _____

NEW PATIENT HISTORY: Pediatric Version (ages 0-12 years)

Allergies:

NONE Foods: _____ Environmental Allergies: _____

Medications: _____

Other: _____

Family History: (please put an "x" in the appropriate box)

Arthritis	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Cancer	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Diabetes	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Heart problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
High Blood Pressure	Mother	Father	Sibling	Grandparent	Aunt/Uncle
High Cholesterol	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Stroke	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Thyroid Problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Obesity	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Liver problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Kidney Problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Depression/Anxiety	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Blood Disorders	Mother	Father	Sibling	Grandparent	Aunt/Uncle

SOCIAL HISTORY

Marital Status: Single

Occupation: Student Disabled

Who lives with you? Home Foster Care Group Home

Education: Current Grade in School _____

Do you use tobacco? Never Quit Date: _____ Smoke (_____ packs per day) Chew

Do you drink alcohol? Never Quit Date: _____ rarely daily weekly special occasions

Are you sexually active? yes no

Females: Date of Last Menstrual Flow: _____

SURGICAL HISTORY:

Type of Surgery	Year of Surgery	Name of Surgeon

MEDICAL HISTORY: Have you ever had any of the following? (check ALL THAT APPLY) NONE

abdominal pain	constipation	fibromyalgia	migraines/headaches
allergies	chronic fatigue	GERD or frequent	osteoporosis
anemia	cancer	heartburn	nerve pain
anxiety	cardiac arrest	high cholesterol	pulmonary embolism
arthritis	celiac disease	hypertension	or blood clot in legs
atrial fibrillation	cystic fibrosis	hypothyroidism	seizures
asthma	depression	heart disease	shortness of breath
bedwetting	diarrhea	insomnia	sinus conditions
bleeding problems	diabetes	irritable bowel syndrome	stroke
bullying	drug/alcohol abuse	kidney problems	Other:
congestive heart failure	frequent or	liver problems	
chest pain	prolonged infections		

Immunizations: Baby Shots are Out of Date Baby Shots Up To Date

Current Medications You Take (please include herbals supplements and any over-the-counter medications):

Signature and Date: