Patient History Form - Newborn to 5 years

Patient Name_____ **DOB**_____

Sex M F History given by_____ **Date**_____

Patient Information:

Are immunizations up to date? Yes or No

Birth History: Was infant born early or late? Yes or No

If yes, how many weeks? _____

What was infants birth weight? _____

Did your child have any respiratory problems, jaundice, or other problems at birth?

_____

Acute Illness / Chronic Illness / Medical Issues: List all past and present diagnoses

_____

_____

Hospitalizations or ER Visits: List any that have occurred since the last well check

_____

_____

Surgeries: List any that have occurred since the last well check

_____

Allergies: _____

Medications: name, dose, what is it given for?

_____

_____

Social History:

Who does the patient live with?

_____

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

_____

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Is your child exposed to tobacco smoke? _____

Any recent travel since the last well check? Yes No Where? _____

Family History - Does anyone in the patients immediate family have any of the following:

Heart Problems/ Heart Attack	Y	N	Migraines/Headaches	Y	N	Allergies	Y	N
High Cholesterol	Y	N	ADHD/ADD	Y	N	Eczema	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Depression or Anxiety	Y	N
Asthma	Y	N	Thyroid Problems	Y	N	Obesity	Y	N
Stomach Problems	Y	N	Bleeding or Clotting Problems	Y	N	Alcoholism	Y	N
Kidney/Bladder Problems	Y	N	Anemia	Y	N	Drug Abuse	Y	N
Seizures	Y	N	Arthritis	Y	N	Cancer	Y	N