Health History Form

**Patients birth to 11 years old**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Existing Patients:** Please check this box and initial if your health history has NOT changed in the last 12 months  \_\_\_\_\_

**Preferred Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City, State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Medication / Supplement** | **Dosage/Strength, Frequency** |
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| **Allergies** | **Reaction** |
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**Are you current on your immunizations:**  YES  NO  UNSURE

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| **General Health History – Check if you have had any of the following** | | | | | | | |
| Arthritis |  | ADHD |  | High Cholesterol |  | Rheumatic Fever |  |
| Asthma |  | Unusual eating behaviors |  | Developmental Delays |  | History of Chemotherapy or Radiation |  |
| Pneumonia |  | Learning Disorders |  | Liver Disease |  | Concerns about your child’s weight |  |
| Allergies – Seasonal / Food |  | Psychosis |  | Intestinal or Stomach Problems |  | Sleep Disorders |  |
| Bladder Problems / Kidney Disease |  | Suicide Attempt |  | Bedwetting |  |  |  |
| Bleeding disorders (sickle cell anemia, hemophilia, low iron) |  | Epilepsy/Seizure Disorder |  | Constipation/Diarrhea |  |  |  |
| Cancer |  | Eye Problems |  | Diabetes I or II |  |  |  |
| Defiant Behaviors |  | Headaches |  | Thyroid Problems |  |  |  |
| Depression/Anxiety |  | Cerebral Palsy |  | Skin Problems |  |  |  |
| Autism |  | Heart Conditions |  | Tuberculosis |  |  |  |
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| Have you ever had any serious illness not listed? If yes, please describe. | | |  | | | | |

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| **Surgical History** | | | | |
| **Date** | **Type of Surgery / Procedure** | | | |
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| **Medical / Psychiatric Hospitalization History** | | | | |
| **Date** | **Reason for Hospitalization** | | | |
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| **Family History** | | | | |
| **Family Member** | | **Status** | **How Old?** | **Medical / Mental Health Illness** |
| Father | | Alive / Deceased |  |  |
| Mother | | Alive / Deceased |  |  |
| Paternal Grandfather | | Alive / Deceased |  |  |
| Paternal Grandmother | | Alive / Deceased |  |  |
| Maternal Grandfather | | Alive / Deceased |  |  |
| Maternal Grandmother | | Alive / Deceased |  |  |
| Sister(s) | | Alive / Deceased |  |  |
| Brother(s) | | Alive / Deceased |  |  |
| Children | | Alive / Deceased |  |  |
| Other Relatives | | Alive / Deceased |  |  |

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| **Social History** | |
| Do you have access to food on an ongoing basis? | YES  NO |
| Do you have access to safe and secure housing? | YES  NO |
| Do you have access to transportation to get to your medical appointments? | YES  NO |
| If you have guns in your house, are they locked and unloaded? | YES  NO |
| Are you a single parent? | YES  NO |
| * Does your child visit the absent parent? | YES  NO |
| * Do you feel comfortable with your child’s safety when your child visits the absent parent? | YES  NO |
| * Do you have anyone available to help with your child? | YES  NO |
| Does anyone in your household smoke? | YES  NO |
| Has your child ever been abused mentally, physical, or sexually? | YES  NO |

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| Has your child been receiving medical care at another office prior to this? | | | YES  NO | |
| If yes, what office? | | | | |
| **Pregnancy** | | | | |
| Did you receive prenatal care? | YES  NO | | | |
| During your pregnancy, did you… | | | | |
| * Smoke cigarettes? | | | | YES  NO If yes, how much? |
| * Drink alcohol? | | | | YES  NO If yes, how much? |
| * Drugs or medications? | | | | YES  NO If yes, how much? |
| **Delivery** | | | | |
| Where was your baby born? | | | | |
| Please check all that apply: Vaginal C-Section Early  On Time Late | | | | |
| **Post Delivery** | | | | |
| How many days did your baby stay in the hospital? | |  | | |
| How did you feed your baby? | | Breast Bottle | | |
| Please list any complications with Pregnancy and/or Delivery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

Please list the name, age, relationship of all other household member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_