NORTHWEST COLORADO HEALTH

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**: _____

Medication / Supplement	Dosage/Strength, Frequency

Allergies	Reaction

Are you current on your immunizations: ☐ YES ☐ NO ☐ UNSURE

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			

Have you ever had any serious illness not listed? If yes, please describe.	

Surgical History	
Date	**Type of Surgery / Procedure**

Medical / Psychiatric Hospitalization History	
Date	**Reason for Hospitalization**

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		

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

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: _____

Revised: 05.10.2017