PATIENT HISTORY FORM

Person completing form: ______________________________ Date: ____________

Child's Name: ______________________________ DOB: ____________

Child's History:

Birth Weight: ____________ Complications at Birth? ______________________________

Hospitalizations & Surgery: ______________________________

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Chronic Illnesses: ______________________________

Significant Injuries: ______________________________

Chicken Pox? ? Yes When? __________ ? No Immunizations Current? ? Yes ? No

Educational & Academic History: ______________________________

______________________________ Current Grade: __________

Other physicians/specialists involved in your child's care ______________________________

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Review of Systems

Please check if your child has any problems in the following body systems.

Problems	No Problems	
?	?	Constitutional (unexplained fevers, weight gain or loss, cancer, leukemia, etc.)
?	?	Eyes
?	?	Ears, Nose, Mouth & Throat (Chronic Ear or Sinus Infections)
?	?	Heart or Blood Vessels (Murmur, High Blood Pressure, etc.)
?	?	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)
?	?	Gastrointestinal Tract (Diarrhea, Constipation, GERD, Liver problems, jaundice)
?	?	Joints, Muscles, Extremities (Arthritis, scoliosis)
?	?	Skin
?	?	Neurological System (ADHD, LD, CP, Seizures, Mental Retardation)
?	?	Psychological or Mental Health (Depression or Anxiety)
?	?	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)
?	?	Blood Disease (Sickle Cell Disease, SC Trait, Hemophilia, etc.)
?	?	Immunology (Chronic Allergies, Immune Deficient)
?	?	Bladder & Kidney (Chronic UTI's, Kidney Problems)

Family History:

Siblings: Name: ______________________________ DOB: ____________

Name: ______________________________ DOB: ____________

Name: ______________________________ DOB: ____________

Name: ______________________________ DOB: ____________

(Over)

Marital Status of Parents: ________________________ Child lives with: ___________________

Are there family circumstances we should know about? ____________________________________

Smokers in house? ? Yes ? No

Firearms in the house? ? Yes ? No

Smoke detectors in house? ? Yes ? No

Pets in home? ? Yes ? No

Water Supply ? City ? Well ? Bottled

Family History:

Please describe any health conditions in your family. Please include the child's parents, brothers, sisters, grandparents (maternal & paternal), aunts and uncles. (check the condition and identify who has the condition in the blank space to the right).

Problems	No Problems		Who	What
?	?	Constitutional (Unexplained fevers, weight loss/gain, Cancer, Leukemia)	____________	____________
?	?	Eyes (Cataracts, crossed eyes, etc.)	____________	____________
?	?	Ears, Nose, Mouth & Throat (Chronic Ear or Sinus Infections)	____________	____________
?	?	Heart or Blood Vessels (Hole in heart, Murmur, High blood pressure, Cholesterol problems Heart Attacks, strokes, etc.)	____________	____________
?	?	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)	____________	____________
?	?	Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)	____________	____________
?	?	Joint, Muscles, Extremities	____________	____________
?	?	Skin	____________	____________
?	?	Neurological System (ADHD, LD, CP, Seizures, Stroke)	____________	____________
?	?	Psychological or Mental Health (Depression or Anxiety)	____________	____________
?	?	Endocrine (Glandular problems, Diabetes, Thyroid disease)	____________	____________
?	?	Blood Disease (Sickle Cell Disease, SC Trait, Hemophilia)	____________	____________
?	?	Immunology (Chronic allergies, Immune deficiency)	____________	____________
?	?	Bladder & Kidney	____________	____________

1st time Provider Reviewed: ______________________________________ Date: ____________

Subsequently reviewed by: ______________________________________ Date: ____________

Subsequently reviewed by: ______________________________________ Date: ____________

Subsequently reviewed by: ______________________________________ Date: ____________