

Patient History

Patient Name: _____ Birth Date: _____ Date: _____

Name all persons living in the patient's home at the present time.

Name	Age	Relationship	Medical Concerns

Family History

Check if any of the patient's parents, brothers, sisters, aunts, uncles or grandparents have had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Anemia, Hemophilia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Attack (less than 60 years of age) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Drug or Alcohol Dependence |
| <input type="checkbox"/> Rheumatoid Arthritis / Lupus | <input type="checkbox"/> Children with Birth Defects |
| <input type="checkbox"/> Thyroid or Endocrine Disease | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stillbirth, Miscarriage or Infant Death |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Has anyone died prior to age 60? |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Is anyone living in the patient's home seriously ill? |
| <input type="checkbox"/> Seizures (Epilepsy) | <input type="checkbox"/> Does anyone living in the patient's home have an immune deficiency? |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Does anyone smoke in the patient's home? |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hay Fever / Allergy | |
| <input type="checkbox"/> Atopic Dermatitis (Eczema) | |

Birth History

Where was the patient born? Birth Weight

Was the patient born: At full term Premature How many weeks Premature?

How many days did the patient stay in the hospital after birth?

Did the patient have any medical problems following birth?

Were there any problems with labor or delivery?

Type of delivery: Vaginal Cesarean Section?

During the pregnancy with this child, did the mother: (check all that apply)

- Smoke?
- Drink alcohol or take drugs?
- Have any illness? Describe: _____
- _____
- Take medications or hormones? Describe: _____
- _____

Maternal Statistics

How many

_____ Pregnancies

_____ Children born full term

_____ Children born premature

_____ Abortions or Miscarriages

has this patient's mother experienced?

_____ How many living children does this patient's mother have?

!!! If your child is less than 1 month old, stop here !!!

Patient's Health History

Is the patient transferring care from another primary healthcare provider? No Yes

Provider's Name: _____ Group/Practice Name: _____

Type of Provider: Doctor Physician's Assistant Nurse Practitioner Location: _____

Other than at birth, has the patient been hospitalized? No Yes

Reason: _____

Location: _____ Age: _____

Has the patient had any surgery? No Yes Describe: _____

Has the patient ever had x-rays? No Yes Describe: _____

Is the patient allergic to any of the following: (Please list type of reaction)

Medications No Yes Foods No Yes
Injections No Yes Other No Yes

Does the patient take: Vitamins Iron Fluoride Other Medications _____

Has the patient ever had any of the following: (check as many as apply)

- Anemia
- Asthma
- Allergic rhinitis
- Atopic Dermatitis (Eczema)
- Urinary Tract Infections
- Pneumonia
- Croup
- Seizures
- Heart Murmur
- High Blood Pressure
- Hepatitis or Jaundice
- Arthritis
- Diabetes
- Strep Throat or Scarlet Fever
- Ear Infections (more than 3 in 1 year)
- Broken Bones
- Head Injuries
- Cuts Requiring Sutures
- Loss of Consciousness
- Accidentally Taken Medications or Poison
- Vision Problems Wears Glasses
- Hearing Problems
- Frequent Headaches
- Frequent Nose Bleeds
- Chronic Cough
- Frequent Stomach Ache
- Frequent Vomiting
- Frequent Diarrhea
- Constipation
- Bed Wetting
- Dental Problems
- Chicken Pox

Other _____

Was there any delay in the patient's learning to: Sit Walk Talk
Does the patient have difficulty in school with: Not in School Leaning Behavior Other _____

How many days of school has the patient missed in the past 6 months? _____

Describe the patient's behavior by marking the appropriate category:

	Major Problem	Minor Problem	No Problem
Short Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot Sit Still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusually Quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overly Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Poor Looser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Getting Along With Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I would like to discuss the following concerns: _____