PEDIATRIC PATIENT HEALTH HISTORY

Patient's Name: ____ DOB: ________________

First Middle Last

Address: ____

City: _________________________________ State: ________ Zip: ________________________

Telephone numbers: Home _____________________________ Work/cell:__________________________

Emergency Contact:____

Relationship: _________________________________ Telephone #: _____________________________

What are the main goals for your visit to our clinic today?

1) ____

2) ____

Are you currently receiving health care by another provider? ☐ Yes ☐ No

If yes, please list your current providers:

____

____

If no, when and where did you last receive medical care?____

Date of last physical exam:__________________________

Have you had any recent bloodwork?

	Date of last test		Date of last test
☐ CBC	________________	☐ Celiac	________________
☐ CMP	________________	☐ Food allergies	________________
☐ Iron Panel	________________	☐ Genetic	________________
☐ Lipids	________________	☐ Other: ________________	
☐ Thyroid	________________		

Are you aware of any allergies to foods, drugs, or other environmental allergens (cats, mold, dust, etc.)? If yes, please list and explain:

____

____

<u>Medications and/or Supplements:</u>

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking, including the <u>brand, dosage and duration</u> you've been taking it if possible:

1. ____
2. ____
3. ____
4. ____

5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

VACCINATIONS:

☐ On schedule ☐ Modified/delayed schedule ☐No vaccinations

Past Immunizations:

☐ Diphtheria ☐ Polio
☐ Measles/Mumps/Rubella (MMR) ☐ Tetanus
☐ Pertussis Other: ______________________________________

Hospitalizations/Surgeries:

Type of illness or operation/procedure	Date	Hospital

Health History:

Y = Yes, present condition P = Problem in the past N = No, never had the condition

Anemia	☐ Y	☐ P	☐ N
Antibiotic use	☐ Y	☐ P	☐ N
Cancer ____________	☐ Y	☐ P	☐ N
Chickenpox	☐ Y	☐ P	☐ N
Diphtheria	☐ Y	☐ P	☐ N
Ear infections	☐ Y	☐ P	☐ N
Food sensitivities	☐ Y	☐ P	☐ N
Hearing loss	☐ Y	☐ P	☐ N
German measles	☐ Y	☐ P	☐ N
Growth Delay	☐ Y	☐ P	☐ N
Heart defect	☐ Y	☐ P	☐ N
Hypothyroid	☐ Y	☐ P	☐ N
Hyperthyroid	☐ Y	☐ P	☐ N
Measles	☐ Y	☐ P	☐ N
Mumps	☐ Y	☐ P	☐ N
Rheumatic fever	☐ Y	☐ P	☐ N
Scarlet fever	☐ Y	☐ P	☐ N
Seizures	☐ Y	☐ P	☐ N
Vision problems	☐ Y	☐ P	☐ N

Other: ____

Family History:

Do you have a family history of any of the following?

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Cancer _______________
☐ Cataracts
☐ Celiac disease
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Gallbladder Disease
☐ Goiter
☐ Hayfever/hives
☐ Headaches/migraines
☐ Heart disease
☐ Heart murmur
☐ High blood pressure
☐ Kidney disease
☐ Liver disease
☐ Mental illness
☐ Skin conditions
☐ Stroke
☐ Suicide
☐ Thyroid problems
☐ Tuberculosis
☐ Other ______________________________

Is your father living? Yes, his age _______ No, age at time of death ______ Cause of death ________________

Is your mother living? Yes, her age _______No, age at time of death ______ Cause of death ________________

Do you have siblings? If so, how is their health?

____

Describe a typical day's diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Fluids:____

Daily intake of water:____

Do you have any dietary restrictions and why?

____

____

Is there anything else you would like us to know in order to serve you better?

____

____

____

Thank you