Health History Form

Name: _____ **DOB:** _____ ☐ Male ☐ Female

Previous Last Name (if different than above): _____

Please list all additional people in your household:

Name	Age	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list additional people on the back

Birth History

Hospital/Place of Birth: _____ Birth Weight: _____

Were there any problems during pregnancy or delivery? ☐ Yes ☐ No

If Yes, please explain: _____

How many weeks pregnant were you when your baby was born? _____

How many days was the baby in the hospital/complications? _____

Did your baby pass their hearing screen? ☐ Yes ☐ No

If No, please explain: _____

Did your baby receive the Hepatitis B vaccine? ☐ Yes ☐ No

Past Medical History

Please list any chronic medical conditions, acute or serious illnesses/injuries: _____

_____

_____

Has child had any surgical procedures? ☐ Yes ☐ No

If Yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If Yes, please explain: _____

Does child have any allergies? ☐ Yes ☐ No

If Yes, please list: _____

Has child been diagnosed with any behavioral problems? ☐ Yes ☐ No

If Yes, please explain: _____

Does child have any problems with Vision/Hearing/Speech? ☐ Yes ☐ No

If Yes, please explain: _____

Does child currently take any medications? ☐ Yes ☐ No

If Yes, please list names and doses: _____

_____

Family History (Please mark all that apply)

Conditions of biological family members ****PLEASE EXPLAIN AND INDICATE WHOM****

☐ Allergies _____

☐ Asthma _____

☐ Lung disease _____

☐ Heart disease _____

☐ High blood pressure _____

☐ High cholesterol _____

☐ Birth defect _____

☐ Cancer _____

☐ Thyroid disease _____

☐ Kidney disease _____

☐ Diabetes _____

☐ Gastrointestinal disease _____

☐ Growth problems _____

☐ Obesity _____

☐ Seizures/Epilepsy _____

☐ Stroke _____

☐ Developmental delay _____

☐ Behavior problems _____

☐ Alcohol and/or drug abuse _____

☐ Depression _____

☐ Mental Illness _____

Have any of the child's siblings died? ☐ Yes ☐ No

If Yes, please explain: _____

Has any family member under the age of 50 died suddenly? ☐ Yes ☐ No

If Yes, please explain: _____

Social History

Relationship of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Not married but living together ☐ Not married, not living together ☐ Widowed ☐ Other

Whom does the child reside with? _____

Do you attend a church and/or have a religious preference? ☐ Yes ☐ No If yes, what _____

Does your child attend daycare/school? ☐ Yes ☐ No ☐ Home schooled

Are there pets in the home? ☐ Yes ☐ No If yes, what _____

Is your home supplied by well water? ☐ Yes ☐ No

Does anyone smoke? ☐ Yes ☐ No Does the patient smoke? ☐ Yes ☐ No

If under the age of 8, does your child use a car seat or booster? ☐ Yes ☐ No

Does your child use a bicycle helmet? ☐ Yes ☐ No ☐ N/A

Are there firearms/weapons in your home? ☐ Yes ☐ No

If Yes, are the lock/stored away from the children? ☐ Yes ☐ No