NEW PATIENT HEALTH INFORMATION

Patient Name: ________________________ **Date of Birth:** _______________

Patient's Past Medical History							
System	**Yes**	**No**	**If yes, describe**	**System**	**Yes**	**No**	**If yes, describe**
Genetic/Neurological				Genitourinary/Kidney			
Vision/Eyes				Bones/Muscle			
Hearing/Ears				Blood/Cancers			
Psychiatric/Behavioral				Endocrine/Glands			
Development/Learning				Infections			
Speech/Swallowing				Menstrual			
Heart/Vasculature				Past Surgeries			
Respiratory/Lungs				Past Hospitalizations			
GI/Digestive				Allergies: (specify)			
Dermatologic/Skin				Sleep Problems: snoring			
Autoimmune Disease				Frequent Headaches			
Obesity				History of Serious Injury			
Other							

Immediate Family Medical History							
Condition	**Yes**	**No**	**If yes, describe**	**Condition**	**Yes**	**No**	**If yes, describe**
Heart Disease under 55				Autoimmune Disease			
High Blood Pressure				Allergies			
Cholesterol				Asthma			
Pulmonary Disease				Eczema			
Diabetes				Birth Defects			
Cancer				Neurological			
Thyroid Disease				Developmental			
Bleeding Disorders				Psychiatric			
Behavioral				Other			

Social History	
Parent's Marital Status	
Siblings(Names)Age/Gender	
Recent visit to ER/Urgent?	**Date and location:**
Smoking in the Home?	
Regular Dental Visits	
Exposure to Lead?	

Birth History					
Birth Weight		Gestational Age?		Vaginal or C Section?	
Hospital Name			Adopted, IVF or Surrogate?		
Any complications?					
During Pregnancy did the Mother:	Use Tobacco ☐ Yes ☐ No	Use Drugs or Medications ☐ Yes ☐ No		Drink Alcohol ☐ Yes ☐ No	

If patient is currently in foster care or has special care arrangements in place, such as custody arrangements, please let our staff know how we can assist you.