New Life CLINIC

Today's Date: _____

Pediatric Medical History From

Child's Name_____ Nickname_____ DOB: _____
Previous Physician/ Office: _____ Date of last Physical: _____
Mother's Name: _____ Age: ___ Father's Name: _____ Age: ___

Birth History:

Birth weight: _____ Delivery: Vaginal Cesarean If Cesarean, why? _____
Was baby born: On time Early Late If early, how many weeks gestation? _____
Did baby have any problems right after brith? Yes No Explain: _____
Was Initial feeding: Breast Milk or Formula
Did baby go home with mother from hospital? Yes No Explain: _____
Did mother have any issues during pregnancy? Yes No Explain: _____
During pregnancy, did mother: Smoke Drink Alcohol Use drugs (what kind) _____ None

Current and Past History:

Is child currently taking any medications: Yes No Explain: _____
Does your child have any serious or chronic illnesses? Yes No Explain: _____
Has child had any serious injuries or accidents? Yes No Explain: _____
Has your child had any surgery? Yes No Explain: _____
Has your child been hospialized? Yes No Explain: _____
Is your child have any allergies to medicine or drugs: Yes No Explain: _____
Has your child had any reactions to an immunization: Yes No Explain: _____

Does child have or ever had:

Athma, recurrent cough, or any lung problems: Yes No Explain: _____
Nasal allergies or eczema: Yes No Explain: _____
Frequent ear infections or sore throat: Yes No Explain: _____
Problems with eyes, vision, or teeth: Yes No Explain: _____
Frequent headache, other neurological issues: Yes No Explain: _____
Frequent abdominal pain or constipation issues: Yes No Explain: _____
Bladder issues or bed-wetting (After age 5): Yes No Explain: _____
Any heart problems or heat murmur: Yes No Explain: _____
Anemia or bleeding problem: Yes No Explain: _____
Thyroid or other Endocrine Problem: Yes No Explain: _____
Diabetes: Yes No Explain: _____
ADHD: Yes No Explain: _____
Mental health issues (anxiety, depression): Yes No Explain: _____
Use of alcohol or drugs: Yes No Explain:_____
Any other medical or mental health issues: _____
Does your child see any specialists: Yes No Who?: _____ Why? _____

Has your child ever received Occupational or Physical Therapy, Speech Therapy: Yes No
Explain:_____
Is your child in special or resource classes in school? Yes No Explain: _____

Household Information:

Please list everyone that is living in the child's home:

Name	**Relationship to Patient**	**DOB**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any siblings that are not? Please list there names, ages and where they live.

_____

Childcare: Daycare Stay at home Custody status: _____
School: _____ Good Grades Average Grades Poor Grades
Pets: _____ Hobbies: _____
Smokers in home: Yes No Smoke Detector: Yes No Guns at Home: Yes No.

Family Medical History: (Parents, Siblings, Grandparents, Aunts, Uncles)

Have any Family Members had the following:

Alcohol/Drug Abuse:	Yes No	Who: _____	Comments: _____	
Allergies:	Yes No	Who: _____	Comments: _____	
Anesthesia Risk:	Yes No	Who: _____	Comments: _____	
Arthritis:	Yes No	Who: _____	Comments: _____	
Blood Disease:	Yes No	Who: _____	Comments: _____	
Cancer:	Yes No	Who: _____	Comments: _____	
Diabetes:	Yes No	Who: _____	Comments: _____	
Gastroentritis:	Yes No	Who: _____	Comments: _____	
Genitourinary:	Yes No	Who: _____	Comments: _____	
Heart or Stroke:	Yes No	Who: _____	Comments: _____	
Hypertension:	Yes No	Who: _____	Comments: _____	
Cholesterol issues:	Yes No	Who: _____	Comments: _____	
Neurologic Diagnosis:	Yes No	Who: _____	Comments: _____	
Mental health issues:	Yes No	Who: _____	Comments: _____	
Eye Issues:	Yes No	Who: _____	Comments: _____	
Respiratory issues:	Yes No	Who: _____	Comments: _____	
Skin problems:	Yes No	Who: _____	Comments: _____	
Thyroid:	Yes No	Who: _____	Comments: _____	

Additional Family History/Comments:

_____