Patient History Form

Chart Number _____ _____ ___/__/___

Patient's First M.I. Last Name Date of Birth

Home Address _____
City State Zip Code

Mother _____ Education Level _____
First M.I. Las

Email _____ Occupation _____ Employer _____

Father _____ Education Level _____
First M.I. Las

Email _____ Occupation _____ Employer _____

Marital Status: (check one) __Married __Separated __ Divorced __Single __ Significant Other

Do Both Biological Parents reside in the home? Yes / No

Non-Residing Parent Address: _____
City State Zip Code

Custodial Parent: _____Parents ____Mother ____Father ____Other **Custody type** ____Sole Custody ___Joint Custody ___Other

House hold Primary Language _____ Total Siblings _____ Name _____ age _____
Name _____ age _____

Total Household Members living in home? _____ Relationship _____ Name _____ age _____

Are there pets within the home? Yes No Type of Pet _____
Does anyone smoke tobacco in the home? Yes No Relationship of smoker _____
Is the family suffering from Financial Hardship? Yes No
(If Yes) does the family have the electric needs met in home? Yes No
Are there smoke alarms in the home? Yes No

Education: ____Attends School ____ Current Grade ____Preschool ____ Daycare ____ In Home Care

Activities ____ Gets along well with peers ____ Participates in sports ____ After school activities

List all current Medications _____ _____ _____

List all Allergies & Reactions

ALLERGY _____ REACTION: _____ ALLERGY _____ REACTION: _____

ALLERGY _____ REACTION: _____

Birth Weight ____lbs ____ oz Gestational age_____ Delivery ___Vaginal ___C-Section
Complications: ____Ventilator ____ Oxygen ____ Jaundice ____ Infections ____ Feeding problems ____None

Medical History _____NO HISTORY

___ADHD/ADD	___Autism	___ Cardiovascular Disease	___High Cholesterol	___ Mental Illness
___Asthma	____ Bleeding disorder	___Diabetes	____ Lung Disease	___Thyroid Disease
___Seasonal Allergies	____ Cancer	___High Blood Pressure	____ Mental Illness	___Seizure Disorder

Surgical History _____NO HISTORY

___Adenoidectomy	___Ear Tubes	___Heart Surgery	___Tonsillectomy	___Other
___Appendectomy	____ Hernia Repair	___Fracture Repair	___Ventricular Shunt	Explain_____

Sibling Medical History – Write B for brother/ S for Sister

___ADHD/ADD	___Autism
___Asthma	____ Blood disorder
____ Seasonal Allergy	____ Cancer
____ Lung Disease	____ Heart Disease
____ Mental Illness	___High Cholesterol
___Thyroid Disease	___Diabetes
___Seizure Disorder	____ Hypertension

_____NO HISTORY

Mothers Medical History

___ADHD/ADD	___Autism
___Asthma	____ Blood disorder
___Allergies	____ Cancer
____ Lung Disease	___Heart Disease
____ Mental Illness	___High Cholesterol
___Thyroid Disease	___Diabetes
___Seizure Disorder	___Hypertension

_____NO HISTORY

Fathers Medical History

___ADHD/ADD	___Autism
___Asthma	____ Blood disorder
___Allergies	____ Cancer
____ Lung Disease	____ Heart Disease
____ Mental Illness	___High Cholesterol
___Thyroid Disease	___Diabetes
___Seizure Disorder	____ Hypertension

_____NO HISTORY