Patient History Form

Chart Number _____ _____ ___/__/___ _____

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

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 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

Total Household Members living in home? _____

Total Siblings _____

Sibling Name _____ age _____
Sibling Name _____ age _____
Sibling Name _____ age _____

House hold Primary Language _____

Are there pets within the home? Yes No Type of Pet _____
Does anyone smoke tobacco in the home? Yes No Relationship of smoker _____
Are there smoke alarms in the home? Yes No

Education: ____Attends School ____ Performs well in school ____Preschool ____ Daycare ____ In Home Care

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

Please list any educational concerns, activity participation or problems with school peers:

_____

List all current Medications, implants or devices _____

List all Allergies & Reactions

ALLERGY _____ REACTION: _____ ALLERGY _____ REACTION: _____

ALLERGY _____ REACTION: _____

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