Health History

Name: ____ Patient's DOB: _____/_____/_______
(Patient Name) (mm) (dd) (yyyy)

Pregnancy / Birth Information

	Yes	No	Explanation
1. Did the child's mother receive prenatal care?			
2. Did the child's mother have any illnesses, infections, or other complications during pregnancy? (If yes, please specify and explain)			
3. Did the child's mother use alcohol, drugs, or tobacco products during pregnancy? (If yes, please specify and explain)			
4. Was the child delivered via Cesarean section? (If yes, please explain why)			
5. Was the child born premature or post-due? (If yes, please specify if the child was born earlier or later)			
6. Were there any complications during the child's stay in the nursery? (If yes, please explain)			
7. Were there any serious problems with the child within 2 weeks after discharge from the nursery? (If yes, please explain)			

Previous Problems

Has the patient experienced any of the following problems? (If yes, please check the box and indicate at what age the problem started or was experienced)

		Age			Age			Age
Asthma			Diabetes			Scoliosis / back problems		
Bedwetting / daytime accidents			Emotional problems			Seizures		
Bladder / kidney infection			Frequent ear infections			Skin problems		
Broken bones			Hearing problems			Sleeping problems		
Chicken pox			Heart problems / murmurs			Speech difficulties		
Concussion			Learning problems			Vision problems		
Other:			Other:			Other:		

Family Health History

Has anyone in the patient's family (parents, grandparents, siblings, aunts, uncles, or cousins) experienced any of the following diseases?
(If yes, please check the box and indicate the relationship of that person to the patient)

	Relationship		Relationship		Relationship
Alcohol abuse / alcoholism		Drug abuse		Learning disability / problems	
Asthma		Heart attack (under 65 y/o)		Mental illness / suicide	
Cancer		Heart problems (other)		Seizures	
Deafness		High blood pressure		Stroke	
Diabetes (adult on-set)		HIV		Sudden unexplained death	
Diabetes (childhood onset)		Kidney disease		Thyroid disease	
Other:		Other:		Other:	

Previous Hospitalizations / Surgeries

Please indicate if the patient has been admitted to the hospital for an overnight stay or has had an surgeries.

Age of Patient	Hospital / Medical Center	City, State	Reason for Hospital Stay / Surgery / Procedure

Allergies

Does the patient have any allergies? □ Yes □ No

Please list all known allergies: ______________________________

Medications

Does the patient currently take any medications? □ Yes □ No

Please list all medications being taken: ______________________________

Other Information

Please use this section to describe any other significant health history issues that you would like to make the doctor aware of:

____

____

____

Form completed by: ______________________________
(Print Name) (Relationship to patient)

Signature: ______________________________ Date: _____/_____/_______
(mm) (dd) (yyyy)