

# NEW PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Form filled out by: Mom Dad Legal Guardian

## Past Medical History:

Birth History: Vaginal delivery C-section Weight: \_\_\_\_\_ Premature: \_\_\_\_\_ Wks. NICU stay: \_\_\_\_\_ Wks.

Any delivery complications? No Yes: \_\_\_\_\_

Abnormal Health History? No Yes: \_\_\_\_\_

Overnight Hospital stays? No Yes: \_\_\_\_\_

Any surgery? No Yes: \_\_\_\_\_

Any Developmental delay? No Yes: \_\_\_\_\_

Any known allergies? No Yes: \_\_\_\_\_

On any medications now? No Yes: \_\_\_\_\_

Psycho-Social Stressors? No Yes: \_\_\_\_\_

**Family History:** Any significant health problems in the family (Mom, Dad, Grandparents)?

No Yes: \_\_\_\_\_

**Social History:** Biological child Adopted Foster care Group home: \_\_\_\_\_

Daycare School: \_\_\_\_\_ Grade Homeschool: \_\_\_\_\_ Grade Smoking inside the house/car

Lives with: Mom Dad Grandparents Foster Parents Other: \_\_\_\_\_

Has this child ever been removed from home (been in foster care)? No Yes: \_\_\_\_\_

Anything else we should know?

---

---

---

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_