

Health History



Name: _____
(Patient Name)

Patient's DOB: ____ / ____ / ____
(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)