# NEW PATIENT HEALTH INFORMATION

**Patient Name:** ______________________ **Date of Birth:** _________________

| Patient's Past Medical History | | | | | | | |
|---|---|---|---|---|---|---|---|
| **System** | **Yes** | **No** | **If yes, describe** | **System** | **Yes** | **No** | **If yes, describe** |
| Genetic/Neurological | | | | Genitourinary/Kidney | | | |
| Vision/Eyes | | | | Bones/Muscle | | | |
| Hearing/Ears | | | | Blood/Cancers | | | |
| Psychiatric/Behavioral | | | | Endocrine/Glands | | | |
| Development/Learning | | | | Infections | | | |
| Speech/Swallowing | | | | Menstrual | | | |
| Heart/Vasculature | | | | Past Surgeries | | | |
| Respiratory/Lungs | | | | Past Hospitalizations | | | |
| GI/Digestive | | | | Allergies: (specify) | | | |
| Dermatologic/Skin | | | | Sleep Problems: snoring | | | |
| Autoimmune Disease | | | | Frequent Headaches | | | |
| Obesity | | | | History of Serious Injury | | | |
| Other | | | | | | | |

| Immediate Family Medical History | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Condition** | **Yes** | **No** | **If yes, describe** | **Condition** | **Yes** | **No** | **If yes, describe** |
| Heart Disease under 55 | | | | Autoimmune Disease | | | |
| High Blood Pressure | | | | Allergies | | | |
| Cholesterol | | | | Asthma | | | |
| Pulmonary Disease | | | | Eczema | | | |
| Diabetes | | | | Birth Defects | | | |
| Cancer | | | | Neurological | | | |
| Thyroid Disease | | | | Developmental | | | |
| Bleeding Disorders | | | | Psychiatric | | | |
| Behavioral | | | | Other | | | |

| Social History | |
|---|---|
| Parent's Marital Status | |
| Siblings(Names)Age/Gender | |
| Recent visit to ER/Urgent? | **Date and location:** |
| Smoking in the Home? | |
| Regular Dental Visits | |
| Exposure to Lead? | |

| Birth History | | | | | |
|---|---|---|---|---|---|
| Birth Weight | | Gestational Age? | | Vaginal or C Section? | |
| Hospital Name | | | Adopted, IVF or Surrogate? | | |
| Any complications? | | | | | |
| During Pregnancy did the Mother: | Use Tobacco ☐ Yes ☐ No | Use Drugs or Medications ☐ Yes ☐ No | Drink Alcohol ☐ Yes ☐ No | | |

***If patient is currently in foster care or has special care arrangements in place, such as custody arrangements, please let our staff know how we can assist you.***