

Patient Health History Information ¹¹⁻¹¹
(Please use the back of this page if you need more space)

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Child lives with: Mom Dad Grandma Grandpa Step-parent Foster parent
(Circle all that apply)

Other relative or guardian: _____

Smokers in the home? Yes No

<u>Child's Siblings</u>	<u>Birthdate</u>	<u>Lives at home?</u>	<u>Illnesses, Surgeries, Accidents, Deaths, etc</u>
_____	_____	Yes No _____	_____
_____	_____	Yes No _____	_____
_____	_____	Yes No _____	_____
_____	_____	Yes No _____	_____

Birth History:

Mother's age at delivery _____ Mother's use of: Alcohol Tobacco Drugs Medications
(Circle all that apply)

Any complications with pregnancy or delivery? _____

Nutrition: Breast fed Yes No To age _____
Formula fed Yes No To age _____ Formula(s) _____

Immunizations are up to date? Yes No Date of last immunization: _____
(Please provide a copy of your child's shot record)

Medical History:

Allergies: _____
(Medications, foods, animals, pollens, seasonal, etc)

Hospitalizations: _____
(Dates and reasons)

Surgeries/Accidents: _____
(Dates and types)

Recurrent or Chronic Illness: _____

Does your child use safety belts or car seats? Yes No