

**Patient Health History Information**

(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