



New Patient Health History Questionnaire

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Past Medical History Has your child had the following? Check box and Explain with year of diagnosis for all items that apply..

- 1) Major concerns from family for child's health
2) Abdominal pain
3) Anemia
4) Asthma
5) Bladder or kidney infection
6) Bleeding Problem
7) Bronchiolitis
8) Bronchitis
9) Constipation
10) Diabetes
11) Ear infections
12) Emotional Problem
13) Eye problem
14) Headaches frequently
15) Hearing loss
16) Heart murmur
17) Heart problem
18) Hospitalization
19) Injuries or accidents
20) Pneumonia
21) Pregnancy or newborn period problems
22) Seizures
23) Serious illness or medical condition
24) Skin problem
25) Thyroid or other endocrine problems
26) Vision problem
27) Other healthcare specialists providing care
28) Other significant problems

Past Medical History (extra space) for Item # with explanations \_\_\_\_\_

Surgery \_\_\_\_\_

Medications prescribed or taken on a regular basis- \_\_\_\_\_

Allergies to medicine or drugs \_\_\_\_\_

Allergies to food or environmental triggers \_\_\_\_\_

Family History: Check if any family members had the following. Please include relationship to child and age at onset.

- Alcohol or Drug abuse
Allergies
Anemia
Asthma
Bleeding Disorder
Cancer
Diabetes
Early/Sudden death
Epilepsy/convulsions
Gastrointestinal problems
Hearing loss/Deafness
Heart disease
High blood pressure
High cholesterol
Immune problems
Kidney disease
Liver Disease
Mental Illness / Depression
Skin Problems
Other significant history

Social History - Who does your child live with? \_\_\_\_\_

Smokers in the household Significant issues in family or household \_\_\_\_\_

Parents' Names, Birthdates, and Employment Info \_\_\_\_\_

Siblings' Names & Birthdates \_\_\_\_\_

With my signature, I state that, to the best of my knowledge, the above answers are correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Initials
EHR Data Entry