Family Medicine in Kirkwood

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PEDIATRIC (<18 yo) New Patient Health History Form <<CONFIDENTIAL>>

First _____ **MI**_____ **Last** _____ **Date of Birth** _____
Mother's Name_____Phone_____
Father's Name_____ Phone_____

Current Medications	Dose	Times per Day	Medication	Dose	Times per day
1			6		
2			7		
3			8		
4			9		
5			10		

Over the counter / Herbals / Supplements?	

Allergies (reaction?):	

Medical Problems (include date):		**Surgeries (include date):**
1	6	1
2	7	2
3	8	3
4	9	4
5	10	5

Prenatal History (fill out as much as possible)
Was patient born full term □Yes □No Number of weeks gestation_____
Birth Weight _____lbs_____oz Birth Length _____ cm Head Circumference _____ cm
Type of birth □Vaginal □C-section If C-section, reason?_____
Mother's age when child was born?_____
Any problems with pregnancy? _____
Any problems with delivery? _____

Social History
Who Lives at home?_____
Siblings (and ages)_____
Are parents □Married □Divorced _____
Does anyone smoke at home? □Yes □No
Any firearms (guns) at home ? □Yes □No
Wears helmet when biking, skateboarding, rollerblading, etc.? □Yes □No
Uses carseat? □Yes □No
Wears seatbelt? □Yes □No
Grade in school _____ Name of School_____ Any Problems?_____

First _____ MI_____ Last _____ Date of Birth _____

--Health Maintenance--

Vaccine	Date(s) of immunizations – **or bring shot record**
Hepatitis A	
Hepatitis B	
DTAP/TDAP (diphtheria, tetanus, pertusis)	
HPV (human papillomavirus)	
HIB (Haemophilus influenzae type b)	
Polio	
PCV (Pneumococcal conjugate)	
RV (Rotavirus)	
MMR (Measles, mumps, rubella)	
Varicella (chickenpox)	
MCV4 (Meningococcal conjugate)	
Influenza / Flu shot	
other	

Family History

Disease	Yes	No	Relationship(mom / dad / sibling / etc?) / Age / Details
Diabetes			
High blood pressure			
High cholesterol			
Heart disease / attack			
Stroke			
Cancer			
Thyroid			
Kidney Disease			
Liver Disease			
Mental Illness			
Asthma			
Seizures			
Bleeding problems			
Other			

Labs / Exams	Date(s)	Result?
Cholesterol (lipids)		
Glucose (diabetes)		
Other		
Eye Doctor		
Dentist		
Females Only		
Pap Smear		

Parent's Signature _____ Date_____