Women's and Children's Specialists, LLC

New Patient Health History Questionnaire

Patient Name: _____ Date of Birth: _____

Who is filling out this form (all that apply) Mother _____ Father _____ Patient _____ Other _____

Briefly, what is the reason for your visit today? _____

Who is most concerned about this problem: Parent(s) _____ Child _____ Your doctor _____

Birth History

Birth Weight _____lb; Birth Length _____in

Pregnancy _____weeks; C-Section? Y _____N _____

Cigarettes: Y _____ N _____Medications? _____

Complications: _____

_____

Newborn Jaundice? _____ Low Blood Glucose? _____

Medical History

Operations Age or Year

_____

_____

_____

Hospitalizations Age or Year

_____

_____

_____

_____

Drug Allergies

_____

_____

_____

Current Medications Dose times/day

(May omit this if the nurse has taken this information)

_____

_____

_____

_____

Development History

Motor milestones: (rolling over, sitting, walking):

On time _____ Later than average _____

Speech: On time _____ Later than average _____

Current grade in school _____

Name of school _____

Grades held back in school advancement? _____

Sports played/physical activities _____

_____

Social History

More than one home? _____

Names of people who live in home with patient.

_____

_____

_____

_____

Father's Occupation: _____

Mother's Occupation: _____

Family History

Mother: Height _____in Age of first menses _____yr

Father: Height _____in Early/average/late puberty

Siblings: First Name	Age	Medical Problems
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Preferred Pharmacy: _____

Phone: (_____) _____

City/town/street _____

OVER

In your immediate family, who has the following illness? (circle all that apply)

Childhood onset (type1) diabetes	FA	MO	GM	GF	SIB
Adult onset (type 2) diabetes	FA	MO	GM	GF	SIB
Low blood sugar	FA	MO	GM	GF	SIB
Hypothyroidism (underactive)	FA	MO	GM	GF	SIB
Hyperthyroidism (overactive)	FA	MO	GM	GF	SIB
Thyroid Cancer	FA	MO	GM	GF	SIB
Celiac Disease	FA	MO	GM	GF	SIB
Ulcerative Colitis	FA	MO	GM	GF	SIB
Crohn's Disease	FA	MO	GM	GF	SIB
Adrenal Disease	FA	MO	GM	GF	SIB
Hypoparathyroidism	FA	MO	GM	GF	SIB

Bone Fractures	FA	MO	GM	GF	SIB
Dark Skin Patches	FA	MO	GM	GF	SIB
White Skin Patches	FA	MO	GM	GF	SIB
Alopecia/Childhood Balding	FA	MO	GM	GF	SIB
Vitamin B-12 Deficiency	FA	MO	GM	GF	SIB
Growth Problems	FA	MO	GM	GF	SIB
Cancer	FA	MO	GM	GF	SIB
Reproductive Problems	FA	MO	GM	GF	SIB
Excessive Hair Growth		MO	GM		SIB
Early Menopause		MO	GM		SIB
High Blood Pressure	FA	MO	GM	GF	SIB

Seizures	FA	MO	GM	GF	SIB
Epilepsy	FA	MO	GM	GF	SIB
Headaches/Migraines	FA	MO	GM	GF	SIB
Head Bleeding	FA	MO	GM	GF	SIB
Stroke	FA	MO	GM	GF	SIB
Aneurysm	FA	MO	GM	GF	SIB
Cerebral Palsy	FA	MO	GM	GF	SIB
Autism	FA	MO	GM	GF	SIB
ADHD/ADD	FA	MO	GM	GF	SIB
Depression	FA	MO	GM	GF	SIB
TICs	FA	MO	GM	GF	SIB

Anxiety	FA	MO	GM	GF	SIB
OCD	FA	MO	GM	GF	SIB
Bi-polar	FA	MO	GM	GF	SIB
Dementia	FA	MO	GM	GF	SIB
Sleep Disorder	FA	MO	GM	GF	SIB

Anemia	FA	MO	GM	GF	SIB
Bleeding Disorder	FA	MO	GM	GF	SIB
Clotting Disorder	FA	MO	GM	GF	SIB
Cancer	FA	MO	GM	GF	SIB
Hysterectomy	FA	MO	GM	GF	SIB
Sickle Cell Disease	FA	MO	GM	GF	SIB
Splenectomy	FA	MO	GM	GF	SIB
Thalassemia	FA	MO	GM	GF	SIB

General:

Are there any smokers in the home? If so, who? _____

Are there any pets in the home? _____

Other conditions in the family that are important: _____

_____

Patient/Guardian: _____ Date: _____