HUB CITY Family Practice LLC

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NEW PATIENT SELF HISTORY FORM – PEDIATRIC

Please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and your child plus target any concerns/issues you may have.

Date this form was completed: ____ / _____ / _____

_____ _____ _____
Child's Last Name Child's First Name Child's MI

Birthdate: _____/ _____/ _____ Age: _____ Sex: ☐ Male ☐ Female

Mother's Name: _____ Birthdate: _____/ _____/ _____

Profession:_____ Employer: _____

Work #: _____ ☐ Cell / ☐Home #: _____

Father's Name: _____ Birthdate: _____/ _____/ _____

Profession:_____ Employer: _____

Work #:_____ ☐ Cell / ☐Home #: _____

Parent's Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Who does the child live with?: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Name of guardian (if applicable):_____

Relationship to child: _____ Name of siblings: _____

List other members in the household: _____

Was your child adopted? ☐ No ☐ Yes If yes, at what age?_____ From what country/city_____

Religious preference (voluntary): _____

MEDICAL HISTORY:

Please list any medical conditions your child has been treated for in the past. (Examples: heart problems, bone or joint problems (bracing/casting), jaundice, allergies, chicken pox, eczema, asthma, strep throat, recurring ear infections, etc.)

_____

_____

SURGICAL / HOSPITALIZATION HISTORY:

Please list ANY surgeries you have had in your lifetime either outpatient or while hospitalized.

Date	Surgery	Location (Hospital, City)	Complication/Other Info

MEDICATIONS: Please list all MEDICATIONS, dosage, and other pills that your child takes including supplements:

_____ _____

_____ _____

PATIENT NAME: _____

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ALLERGIES:

Latex Allergy: ☐ No ☐ Yes (if yes, list reaction) _____

Please check box if your child has NO KNOWN Allergies: ☐

Other Allergies (i.e. Bees, food, shellfish – please list reaction)**:** _____

Drug Allergies: ☐ No ☐ Yes (if yes, list **drug** and type of **reaction** below)

_____ _____

_____ _____

_____ _____

IMMUNIZATIONS: ***Please provide us with an updated list of your child's immunizations!***

FAMILY HISTORY:

Please check any medical conditions/diseases in your family. These should be serious illnesses of mother, father, or siblings. Please indicate beside the illness, **F=Father**, **M= Mother**, **B= Brother, S= Sister**

☐ No Known Family History
☐ Abdominal Aortic Aneurysm _____
☐ Alcoholism _____
☐ Alzheimer's Disease _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer (Breast) _____
☐ Cancer (Colon) _____
☐ Cancer (Lung) _____
☐ Cancer (Ovarian) _____
☐ Cancer (Prostate) _____
☐ Cataracts _____
☐ Cirrhosis _____
☐ Congenital Heart Disease _____
☐ Congestive Heart Failure _____
☐ Depression _____
☐ Diabetes _____
☐ Emphysema _____
☐ Glaucoma _____
☐ Gout _____
☐ Heart Disease _____
☐ Hemophilia (Bleeding Disorder) _____
☐ High Cholesterol _____
☐ Hypertension _____
☐ Kidney Failure _____
☐ Kidney Stones _____
☐ Migraine Headaches _____
☐ Osteoporosis _____
☐ Overactive Thyroid _____
☐ Parkinson's Disease _____
☐ Underactive Thyroid _____
☐ Unknown _____
☐ Vein Disorders _____
☐ Other_____
_____
_____

Do family members smoke outside? ☐ No ☐ Yes

Do family members smoke inside? ☐ No ☐ Yes

Is daycare used? ☐ No ☐ Yes

MOM'S PREGNANCY HISTORY:

Number of pregnancies before this child (including miscarriages)_____

How long was this pregnancy (# of weeks)_____

When was prenatal care started for this child (months pregnant): _____

List any illnesses you experienced during this pregnancy (high blood pressure, diabetes, thyroid problems)

_____ _____

_____ _____

List any medications you took during the pregnancy:

_____ _____

_____ _____

Did you smoke during pregnancy? **Yes No** Any alcohol consumption? ☐ No ☐ Yes Any drug use? ☐ No ☐ Yes

PATIENT'S BIRTH HISTORY:

Length of labor (hours) _____ Was labor induced? ☐ No ☐ Yes If yes, why? _____

Delivery (check all that apply): ☐ Breech presentation ☐ C-section ☐ VBAC ☐ Breathing problems ☐ Vacuum Forceps

Nursery: (check all that apply): ☐ Neonatal ☐ ICU admission ☐ Antibiotics ☐ Lights for jaundice ☐ Blood transfusion ☐ Oxygen needed

Birth weight: _____ Birth length: _____ Discharge weight: _____

Apgar score: _____ Time spent in hospital: _____

Newborn screen performed in hospital? ☐ No ☐ Yes Hepatitis B vaccine given in nursery? ☐ No ☐ Yes

Please describe any other problems: _____

NUTRITION HISTORY:

Breast fed? ☐ No ☐ Yes Duration:_____

Formula fed? ☐ No ☐ Yes Type of formula:_____ Duration:_____

At what age were solid foods introduced? _____ Does your child use a pacifier? ☐ No ☐ Yes

Is your child taking vitamins? ☐ No ☐ Yes Is your child using a fluoride supplement? ☐ No ☐ Yes

Any feeding issues? (check all that apply) ☐ Vomiting or reflux ☐ Colic ☐ Diarrhea ☐ Other _____

GROWTH AND DEVELOPMENT:

What age did your child perform the following?

Sat alone: _____ Walked alone:_____ Potty trained (day): _____ Potty trained (night): _____

Talked in 2-3 word sentences: _____

Any problems in school? ☐ No ☐ Yes (if yes please provide some details) _____

_____

Any behavioral problems? ☐ No ☐ Yes (if yes please provide some details) _____

_____

Any developmental concerns? ☐ No ☐ Yes (if yes please provide some details) _____

_____

For Girls Only: Have you started your period? ☐ No ☐ Yes If yes, at what age? _____

Pharmacies: (list your preferred pharmacy)		**Street Name**	**City, State**
Local Pharmacy Name:			
Mail Order Pharmacy Name:			

THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

_____ _____/ _____/ _____

Parent / Guardian Signature (relationship to patient) or Power of Attorney Date

Print Name:_____

Reviewed by Hub City Family Practice: _____ _____/ _____/ _____

Date