

## New Patient Health History Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex M / F  
 Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex M / F  
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 Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex M / F

*Does your child have any of the following problems, or is there a family history of any problems in the following areas? If yes, please explain:*

	<i>Your Child</i>	<i>Your Child's Family</i>	<i>Explanation:</i>
Allergies			
Diabetes			
Heart problems			
High Blood Pressure			
Lung Problems			
Asthma/ Breathing problems			
Broken Bones			
Skin problems			
Cancer			
Emotional			
Mental illness			
School Difficulties			
Other			

Has your child ever had chickenpox disease? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Is your child taking any kind of medication (prescribed, over-the-counter, or herbal)? \_\_\_\_\_  
 If yes, what kind and how often:

Has your child ever been hospitalized for any reason? If yes, please give date and reason.

Is there anything else you feel we should know about your child?

\_\_\_\_\_  
 SIGNATURE OF PERSON FILLING OUT FORM

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 RELATION TO PATIENT