

Patient Name _____ Birthdate _____

Patient History

Family

Mother's Name _____ Father's Name _____
 Birthdate _____ Married() Div() Single() Birthdate _____ Married() Div() Single()
 Address _____ Address _____
 City _____ St _____ Zip _____ City _____ St _____ Zip _____
 Home Phone _____ Home Phone _____
 Cell Phone _____ Cell Phone _____
 Occupation _____ Occupation _____

Primary Insurance _____ ID# _____ Group# _____
 Policy Holder Name _____ DOB _____
 Mother () Father () Step-parent ()

Secondary Insurance _____ ID# _____ Group# _____
 Policy Holder Name _____ DOB _____
 Mother () Father () Step-parent ()

Home

Who lives in the home _____
 Sibling _____ Birthdate _____
 Sibling _____ Birthdate _____
 Sibling _____ Birthdate _____
 Sibling _____ Birthdate _____

Family History

 Check any illness or diseases that have been found in relatives

<input checked="" type="checkbox"/>	Illness or Disease	Type of Relative	<input checked="" type="checkbox"/>	Illness or Disease	Type of Relative
<input type="checkbox"/>	Anemia		<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Attention Deficit		<input type="checkbox"/>	Bleeding/Clotting Problems	
<input type="checkbox"/>	Cancer		<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Heart Attack before 55		<input type="checkbox"/>	High Cholesterol/Blood Pressure	
<input type="checkbox"/>	Learning Disability		<input type="checkbox"/>	Mental Illness	
<input type="checkbox"/>	Migraines		<input type="checkbox"/>	Substance Abuse	
<input type="checkbox"/>	Thyroid Disease		<input type="checkbox"/>	Crohn's/Ulcerative Colitis	
<input type="checkbox"/>	Other:		<input type="checkbox"/>	Other:	

Social History

Well water Yes No House built before 1960 Yes No
 Smoke exposure Yes No Smoke detectors Yes No
 Guns in home Yes No If yes, where _____
 Child ever lived outside US Yes No If yes, what type _____
 Pets Yes No

Past Medical History

Birth History Weight _____ Days spent in hospital _____ Breast or Formula Fed _____
 Past Medical Problems _____
 Hospitalizations _____
 Surgeries _____
 Known Drug Allergies _____