University Medical Center

Updated as of 6/04/14
Supersedes all prior versions

New Patient History Form
6 to 18 years

Child's Full Name: _____
First Middle Last

Birth Date: ___ /___ /___ Age: ___ years Gender: Male ___ Female ___ Today's Date: _____

Child is presently living with the following people (check [V] all that apply):

___ Natural Mother ___ Natural Father ___ Step Mother ___ Step Father
___ Adoptive Mother ___ Adoptive Father ___Foster Mother ___ Foster Father
___Grandmother ___ Grandfather ___ Split time between 2 homes
___Other(specify)

Where does this child live(circle one): House Apartment Trailer Other (describe) _____

Any pets in the home? NO___ YES___
Any smokers in the home? NO___ YES___
Does child stay at daycare center or baby-sitters? NO___ YES___
Does home have air conditioning? YES___ NO___

Parents' History

Mother:

Name: _____ Age ____yrs ___ Natural ___ Step Other _____
Occupation: _____ Highest grade completed in school: ____
Any health problems: ___ No ___ Yes (If yes, describe) _____

Father:

Name: _____ Age ____yrs ___ Natural ___ Step Other _____
Occupation: _____ Highest grade completed in school: ____
Any health problems: ___ No ___ Yes (If yes, describe) _____

	Brothers & Sisters Names	Dates of Birth	Gender (circle)	Lives at home (circle)
1.			M F	No Yes
2.			M F	No Yes
3.			M F	No Yes
4.			M F	No Yes
5.			M F	No Yes

Child's Medical History:

Newborn & Infancy Period:

Child was born: ___ On time ___ Early ___ Late Birth Weight: ___ lb. ___ oz. (or ____ gm)
Delivery was: ___ Vaginal ___ c/section Number of days infant was in hospital after birth: _____
Any problems during the pregnancy? NO___ YES___
Any problems during delivery? NO___ YES___
Any problems during first days after birth? NO___ YES___

Present Medical Condition:

1. Does child have any vision or hearing problems? NO___ YES___
2. Does your child have problems with bedwetting? NO___ YES___
3. Is your child behind on his/her vaccines? NO___ YES___
4. Is child being treated for any illnesses currently? NO___ YES___
   If YES, please list:
5. Is child taking any medications currently? NO___ YES___
   If YES, please list:

University Medical Center
New Patient History Form
6 to 18 years

Health Care Providers: **page 2**

1. Who has child seen most recently for routine healthcare visits (medical care)?
2. Does child see any specialists at current time: ___ No ___ Yes
   If yes, list their names:

Has child had any of the following problems?

Problem	No	Yes	If yes, please describe
Allergies (food, pollen, dust, etc.)?			
Allergies or problems with medications?			
Anemia (low blood count)?			
Behavior problems?			
Broken bones?			
Convulsions (seizures)?			
Fainting spells?			
Frequent or recurrent infections?			
Head injuries or knocked unconscious?			
Hospital stays overnight?			
Meningitis?			
Operations (surgeries)?			
School or learning problems?			
Sleep problems?			
Wheezing or asthma?			
Any other serious illness?			

Developmental History (for children under 10 years of age, what age did your child start doing the following)

Walking____ said first words____ Talked in sentences____
Was potty trained____ Tied own shoes____ Dressed Self____
Rode a bicycle____ Started reading____

School History

1. Child's Current School_____
2. Has your child ever repeated any grades? NO___ YES___ If yes, list grades repeated
3. Has your child been placed in any special classes? NO___ YES___If yes, list the classes

University Medical Center
New Patient History Form
6 to 18 years

Family History: (Has anyone in your family had any of the following problems: If so, place a check mark (√) in the column underneath all family members who have the problem.)

Problem	Mother	Father	Brother	Sister	Grandparent	Uncle/Aunt	OtherFamily
ADHD or learning problems							
Allergies							
Anemia (low blood count)							
Asthma							
Cancer (including leukemia)							
Cystic Fibrosis							
Diabetes							
Eye problems or poor vision							
Hearing problems or deafness							
Heart attack that occurred < 55 yrs							
High blood pressure							
High cholesterol in blood							
Kidney or bladder problems							
Mental health problems							
Mental retardation							
Migraine headaches							
Seizures or Epilepsy							
Sickle Cell Disease							
Skin problems							
Stroke that occurred < 55 yrs							
Thyroid Disease							
Tuberculosis (TB)							

Reviewed by: _____, M.D.

Signature _____ **Relationship to Patient**_____