University Medical Center

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

New Patient History Form
Birth to 5 years

Child's Full Name: _____
First Middle Last

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

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

___ Natural Mother ___ Natural Father ___ Step Mother ___ Step Father
___ Adoptive Mother ___ Adoptive Father ___ Foster Mother ___ Foster Father
___ Grandmother ___ Grandfather

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:

Mother's Pregnancy: (check any of the following that happened during the pregnancy)

Any illnesses? NO___ YES___
Any Smoking? NO___ YES___
Any medications or alcohol taken? NO___ YES___

Newborn & Infancy Period:

Child was born: on time___ early___ late___ birth weight:_____lb._____oz. (or _____ gm)
Delivery was: vaginal___ c/section___ Number days infant was in the hospital after birth?_____
Any problems during the delivery? NO___ YES___
Any problems during the first days after birth? NO___ YES___
If yes, please list the problems:

Present Medical Condition:

Does child have any vision or hearing problems? NO___ YES___
Is child being treated for any illnesses currently? NO___ YES___
If yes, please list:

Is child taking any medications currently? NO___ YES___
If yes, please list:

Does your child see any specialists at the current time? NO___ YES___

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Has child had any of the following problems?

Problem	NO	YES	If yes, please describe
Allergies to food or medicines?			
Anemia(low blood count)?			
Broken bones?			
Colic or extreme fussiness?			
Convulsions?			
Difficulty feeding or picky eater?			
Fainting spells?			
Frequent or recurrent infections?			
Head injuries or knocked unconscious?			
Hospital stays overnight?			
Operations(surgeries)?			
Sleep problems?			
Wheezing or asthma?			
Any other serious illness?			

Developmental History { check (√) all of the acts that your child can do & write the age it first happened}

Action (children under 2 years)	√	Age
Smiles at you		
Laughs out loud		
Coos & gurgles		
Turns toward interesting sounds		
Grasps an object with hand		
Rolls over both ways		
Sits up by self		
Crawls		
Pulls up to a standing position		
Walks down side of furniture		
Took first steps without holding on		

Action(children 2 years & older)	√	Age
Took first steps without holding on		
Said first words		
Recognized his/her own name		
Starting running		
Walks up steps by self		
Talked in sentences		
Potty trained		
Pedaled a tricycle		
Dresses self with little help		
Reads a book by self		
Rides a bicycle		

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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 (type _____)							
Cystic Fibrosis							
Diabetes (type _____)							
Eye problems or poor vision							
Genetic disorder (type _____)							
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_____