NEW PATIENT HEALTH HISTORY FORM
PEDIATRIC

HUNTER HEALTH

BASIC INFORMATION

REASON FOR VISIT	TODAY'S DATE

FIRST NAME	LAST NAME	DATE OF BIRTH

PRIMARY CARE PHYSICIAN	PREFERRED PHARMACY

SEX AT BIRTH MALE FEMALE	**GENDER IDENTIFICATION** (ex. male, female, transgender, gender neutral, non-binary...)

FORM COMPLETED BY	RELATIONSHIP TO PATIENT

HOUSEHOLD (list all people living in the child's home)

RELATIONSHIP TO CHILD	NAME	DATE OF BIRTH	HEALTH PROBLEMS

LIST ANY SIBLINGS THAT THE CHILD DOES NOT LIVE WITH:

CHILD'S LIVING SITUATION

☐ BIOLOGICAL FAMILY ☐ FOSTER FAMILY ☐ SINGLE CUSTODY
☐ ADOPTIVE PARENTS ☐ JOINT CUSTODY ☐ **OTHER (describe)** _____

If one or both parents are NOT living in the home, how often does the child see the parent? _____

BIRTH HISTORY

BIRTH WEIGHT ____ LBS ____ OZ

WAS THE BABY BORN AT TERM (37 weeks or more)?
YES / NO
HOW MANY WEEKS? _____

WHERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS?
YES / NO
IF YES, PLEASE EXPLAIN: _____

WAS A NICU STAY REQUIRED?
YES / NO
IF YES, PLEASE EXPLAIN: _____

DELIVERY: **VAGINAL / CESAREAN**

WAS THE INITIAL FEEDING: **FORMULA / BREAST MILK**
HOW LONG BREASTFED? _____

DID THE BABY GO HOME WITH MOTHER FROM THE HOSPITAL?

DURING PREGNANCY, DID THE MOTHER:
USE PRENATAL VITAMINS? **YES / NO**
USE TOBACCO? **YES / NO**
IF YES, HOW MUCH? _____

USE ALCOHOL? **YES / NO**
IF YES, HOW MUCH? _____

USE DRUGS OR MEDICATIONS? **YES / NO**
IF YES, WHAT KIND AND WHEN? _____

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MEDICATIONS

CURRENT MEDICATIONS (include dose and frequency)	**MEDICATION ALLERGIES**
	YES / NO / DON'T KNOW *Please list:*

GENERAL HEALTH

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? **YES / NO / DON'T KNOW**
EXPLAIN:

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS? **YES / NO / DON'T KNOW**
EXPLAIN:

HAS YOUR CHILD HAD ANY SURGERY? **YES / NO / DON'T KNOW**
EXPLAIN:

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? **YES / NO / DON'T KNOW**
EXPLAIN:

DO YOU FEEL YOUR FAMILY HAS ENOUGH TO EAT? **YES / NO / DON'T KNOW**
EXPLAIN:

BIOLOGICAL FAMILY HISTORY

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING?	**WHAT FAMILY MEMBER?**
CHILD HEARING LOSS **YES / NO / DON'T KNOW**	
NASAL ALLERGIES **YES / NO / DON'T KNOW**	
ASTHMA **YES / NO / DON'T KNOW**	
TUBERCULOSIS **YES / NO / DON'T KNOW**	
HEART DISEASE (BEFORE AGE 55) **YES / NO / DON'T KNOW**	
HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION **YES / NO / DON'T KNOW**	
ANEMIA **YES / NO / DON'T KNOW**	
BLEEDING DISORDER **YES / NO / DON'T KNOW**	
DENTAL DECAY **YES / NO / DON'T KNOW**	
CANCER (BEFORE AGE 55) **YES / NO / DON'T KNOW**	
LIVER DISEASE **YES / NO / DON'T KNOW**	
KIDNEY DISEASE **YES / NO / DON'T KNOW**	
DIABETES (BEFORE AGE 55) **YES / NO / DON'T KNOW**	
BED-WETTING (AFTER AGE 10) **YES / NO / DON'T KNOW**	
OBESITY **YES / NO / DON'T KNOW**	
EPILEPSY OR CONVULSIONS **YES / NO / DON'T KNOW**	

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BIOLOGICAL FAMILY HISTORY

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING?	WHAT FAMILY MEMBER?
ALCOHOL ABUSE **YES / NO / DON'T KNOW**	
DRUG ABUSE **YES / NO / DON'T KNOW**	
MENTAL ILLNESS/DEPRESSION **YES / NO / DON'T KNOW**	
DEVELOPMENTAL DISABILITY **YES / NO / DON'T KNOW**	
IMMUNE PROBLEMS, HIV OR AIDS **YES / NO / DON'T KNOW**	
TOBACCO USE **YES / NO / DON'T KNOW**	
ADDITIONAL HISTORY NOT LISTED:	

CHILD PAST HISTORY

DOES YOUR CHILD HAVE, OR PREVIOUSLY HAD THE FOLLOWING?

CHICKEN POX **YES / NO / DON'T KNOW**
WHEN:

FREQUENT EAR INFECTIONS **YES / NO / DON'T KNOW**
EXPLAIN:

PROBLEMS WITH EARS OR HEARING **YES / NO / DON'T KNOW**
EXPLAIN:

NASAL ALLERGIES **YES / NO / DON'T KNOW**
EXPLAIN:

PROBLEMS WITH EYES OR VISION **YES / NO / DON'T KNOW**
EXPLAIN:

ASTHMA, BRONCHITIS, BRONCHIOLITIS OR PNEUMONIA **YES / NO / DON'T KNOW**
EXPLAIN:

ANY HEART PROBLEM OR HEART MURMUR **YES / NO / DON'T KNOW**
EXPLAIN:

ANEMIA OR BLEEDING PROBLEM **YES / NO / DON'T KNOW**
EXPLAIN:

BLOOD TRANSFUSION **YES / NO / DON'T KNOW**
EXPLAIN:

HIV **YES / NO / DON'T KNOW**
EXPLAIN:

ORGAN TRANSPLANT **YES / NO / DON'T KNOW**
EXPLAIN:

MALIGNANCY/BONE MARROW TRANSPLANT **YES / NO / DON'T KNOW**
EXPLAIN:

CHEMOTHERAPY **YES / NO / DON'T KNOW**
EXPLAIN:

FREQUENT ABDOMINAL PAIN **YES / NO / DON'T KNOW**
EXPLAIN:

CONSTIPATION REQUIRING DOCTOR VISITS **YES / NO / DON'T KNOW**
EXPLAIN:

RECURRENT URINARY TRACT INFECTIONS **YES / NO / DON'T KNOW**
EXPLAIN:

CONGENITAL CATARACTS/RETINOBLASTOMA **YES / NO / DON'T KNOW**
EXPLAIN:

CANCER **YES / NO / DON'T KNOW**
EXPLAIN:

NEW PATIENT HEALTH HISTORY FORM
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CHILD PAST HISTORY (CONTINUED)

KIDNEY DISEASE OR UROLOGIC MALFORMATIONS **YES / NO / DON'T KNOW**
EXPLAIN: _____

BED-WETTING (AFTER AGE 5) **YES / NO / DON'T KNOW**
EXPLAIN: _____

SLEEP PROBLEMS/SNORING **YES / NO / DON'T KNOW**
EXPLAIN: _____

CHRONIC OR RECURRENT SKIN PROBLEMS (ACNE, ECZEMA) **YES / NO / DON'T KNOW**
EXPLAIN: _____

FREQUENT HEADACHES **YES / NO / DON'T KNOW**
EXPLAIN: _____

CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS **YES / NO / DON'T KNOW**
EXPLAIN: _____

OBESITY **YES / NO / DON'T KNOW**
EXPLAIN: _____

DIABETES **YES / NO / DON'T KNOW**
EXPLAIN: _____

THYROID OR OTHER ENDOCRINE PROBLEMS **YES / NO / DON'T KNOW**
EXPLAIN: _____

HIGH BLOOD PRESSURE **YES / NO / DON'T KNOW**
EXPLAIN: _____

HISTORY OF SERIOUS INJURY/FRACTURES/CONCUSSIONS **YES / NO / DON'T KNOW**
EXPLAIN: _____

USE OF ALCOHOL, TOBACCO, OR DRUGS **YES / NO / DON'T KNOW**
EXPLAIN: _____

ADHD/ANXIETY/DEPRESSION **YES / NO / DON'T KNOW**
EXPLAIN: _____

DEVELOPMENTAL DELAY **YES / NO / DON'T KNOW**
EXPLAIN: _____

DENTAL DECAY **YES / NO / DON'T KNOW**
EXPLAIN: _____

HISTORY OF FAMILY VIOLENCE **YES / NO / DON'T KNOW**
EXPLAIN: _____

SEXUALLY TRANSMITTED INFECTIONS **YES / NO / DON'T KNOW**
EXPLAIN: _____

(FOR GIRLS) PREGNANCY **YES / NO / DON'T KNOW**
EXPLAIN: _____

(FOR GIRLS) PROBLEMS WITH PERIOD **YES / NO / DON'T KNOW**
EXPLAIN: _____ AGE OF FIRST PERIOD: _____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PROVIDER SIGNATURE: _____ **DATE:** _____