

NEW PATIENT MEDICAL HISTORY

Patient Name: DOB:/ DOB:/
First Last
Primary Care Provider:
Phone: City/State:
BIRTH HISTORY Circle one: Full-term (at least 37 weeks) / Preterm (wks)
Birth Weight: Birth Length:
Birth Hospital: City/State:
Pregnancy Complications:
Birth Complications:
Post-delivery Problems:
MEDICAL HISTORY Check all that apply or circle: NONE
Has the patient ever been diagnosed with any of the following conditions? ADHD/ADD
ALLERGIES List all food & medication allergies or circle: NONE
Has the patient ever had a serious injury such as a broken bone or concussion? If yes, please explain:
Has the patient ever been in speech, occupational, or physical therapy? Y / N Is the patient currently in speech, occupational, or physical therapy? Y / N If yes, please explain:
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Other surgeries not listed		tonsil removal shunt placement				_adenoid removal gastrostomy tub	
	above:						
AMILY HISTORY (Check all	that appl	y or circle:	NONE			
Relation	Mom	Dad	Sibling	Grand- parent	Aunt	Uncle	
Heart attack							
Heart failure							
Stroke							
High blood pressure							
High cholesterol							
Diabetes							
Polycystic Ovary Syndrome							
Thyroid disorder							
Thyroid nodule							
Thyroid cancer							
Genetic disorder							
Lupus							
Rheumatoid Arthritis							
Crohn's Disease							
Ulcerative Colitis							
Multiple Sclerosis							
Psoriasis							