Women's and Children's Specialists, LLC

New Patient Health History Questionnaire

Patient Name: _____ Date of Birth: _____

Who is filling out this form (all that apply) Mother ☐ Father ☐ Patient ☐ Other ☐

Briefly, what is the reason for your visit today? _____

Who is most concerned about this problem: Parent(s) ☐ Child ☐ Your doctor ☐

Birth History

Birth Weight _____lb; Birth Length _____in

Pregnancy _____weeks; C-Section? Y ☐ N ☐

Cigarettes: Y ☐ N ☐ Medications? _____

Complications: _____

_____

Newborn Jaundice? ☐ Low Blood Glucose? ☐

Medical History

Operations Age or Year

_____

_____

_____

Hospitalizations Age or Year

_____

_____

_____

_____

Drug Allergies

_____

_____

_____

Current Medications Dose times/day

(May omit this if the nurse has taken this information)

_____

_____

_____

_____

Development History

Motor milestones: (rolling over, sitting, walking):

On time ☐ Later than average ☐

Speech: On time ☐ Later than average ☐

Current grade in school _____

Name of school _____

Grades held back in school advancement? _____

Sports played/physical activities _____

_____

Social History

More than one home? _____

Names of people who live in home with patient.

_____

_____

_____

_____

Father's Occupation: _____

Mother's Occupation: _____

Family History

Mother: Height _____in Age of first menses _____yr

Father: Height _____in Early/average/late puberty ☐ ☐ ☐

Siblings: First Name	Age	Medical Problems

Preferred Pharmacy: _____

Phone: (_____) _____

City/town/street _____

OVER

In your immediate family, who has the following illness? (circle all that apply)

	FA	MO	GM	GF	SIB
Childhood onset (type1) diabetes	☐	☐	☐	☐	☐
Adult onset (type 2) diabetes	☐	☐	☐	☐	☐
Low blood sugar	☐	☐	☐	☐	☐
Hypothyroidism (underactive)	☐	☐	☐	☐	☐
Hyperthyroidism (overactive)	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐
Adrenal Disease	☐	☐	☐	☐	☐
Hypoparathyroidism	☐	☐	☐	☐	☐

	FA	MO	GM	GF	SIB
Bone Fractures	☐	☐	☐	☐	☐
Dark Skin Patches	☐	☐	☐	☐	☐
White Skin Patches	☐	☐	☐	☐	☐
Alopecia/Childhood Balding	☐	☐	☐	☐	☐
Vitamin B-12 Deficiency	☐	☐	☐	☐	☐
Growth Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Reproductive Problems	☐	☐	☐	☐	☐
Excessive Hair Growth		☐	☐		☐
Early Menopause		☐	☐		☐
High Blood Pressure	☐	☐	☐	☐	☐

	FA	MO	GM	GF	SIB
Seizures	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐
Head Bleeding	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
TICs	☐	☐	☐	☐	☐

	FA	MO	GM	GF	SIB
Anxiety	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐
Bi-polar	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐

	FA	MO	GM	GF	SIB
Anemia	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Hysterectomy	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐
Splenectomy	☐	☐	☐	☐	☐
Thalassemia	☐	☐	☐	☐	☐

General:

Are there any smokers in the home? If so, who? _____

Are there any pets in the home? _____

Other conditions in the family that are important: _____

_____

Patient/Guardian: _____ Date: _____