Concord Children Clinic

PATIENT HISTORY FORM

Person Completing Form: _____ Date Form Completed: _____

Child's Name _____ DOB: _____

Child's History

Describe Your Child's Health: _____

Birth Weight: _____ Complications at Birth? _____

Current Medications: _____

Drug Allergies _____

Hospitalizations and Surgery: _____

_____

Extended Illnesses: _____

Significant Injuries: _____

Chicken Pox? ☐ Yes ☐ No Immunizations Current ☐ Yes ☐ No

Describe Your Child's Growth: _____

Describe Your Child's Development: _____

Describe the Temperament of Your Child: _____

_____

Current School: _____ Current Grade: _____

Educational and Academic History: _____

Reviewed: _____ Date _____ _____

_____ _____

_____ _____

Review of Systems

Please check if your child has any problems in the following body systems.

Problems	No Problems	
☐	☐	Constitutional (Unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol)
☐	☐	Eyes (Cataracts, Cross Eyes)
☐	☐	Ears, Nose, Mouth and Throat (Chronic Ear or Sinus Infections)
☐	☐	Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack)
☐	☐	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)
☐	☐	Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)
☐	☐	Joints, Muscles, Extremities
☐	☐	Skin
☐	☐	Neurological System (ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)
☐	☐	Psychological or Mental Health (Depression or Anxiety)
☐	☐	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)
☐	☐	Blood Disease (SCA, Sickle Trait)
☐	☐	Immunology (Chronic Allergies, Weak Immune System)
☐	☐	Bladder & Kidney (Chronic Bladder Infections, Kidney Failure)

First Time Provider Reviewed: _____ Date: _____

Reviewed: _____

_____

_____

Person Completing Form: _____ Date Form Completed: _____

Child's Name _____ DOB: _____

Social History

Mother's Name: _____ Occupation _____ DOB _____

Father's Name: _____ Occupation _____ DOB _____

Siblings: Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Marital Status of parents: _____

Child lives with: _____

Are there any family circumstances we should know about? _____

Smokers in house? Yes No Who? _____

Firearms in house? Yes No

Smoke detectors in the house? Yes No

Pets (Describe): _____

Religious Preference: _____

Family History

Please describe any health conditions in your family. Please include the child's parents, brothers, sisters, grandparents (maternal and paternal), aunts and uncles. (check the condition and identify who has the condition in the blank space to the right).

Problems	No Problems		Who	What
☐	☐	Constitutional (Unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol)	_____ :	_____
☐	☐	Eyes (Cataracts, Cross Eyes)	_____ :	_____
☐	☐	Ears, Nose, Mouth and Throat (Chronic Ear or Sinus Infections)	_____ :	_____
☐	☐	Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack)	_____ :	_____
☐	☐	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)	_____ :	_____
☐	☐	Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)	_____ :	_____
☐	☐	Joints, Muscles, Extremities	_____ :	_____
☐	☐	Skin	_____ :	_____
☐	☐	Neurological System (ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)	_____ :	_____
☐	☐	Psychological or Mental Health (Depression or Anxiety)	_____ :	_____
☐	☐	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)	_____ :	_____
☐	☐	Blood Disease (SCA, Sickle Trait)	_____ :	_____
☐	☐	Immunology (Chronic Allergies, Weak Immune System)	_____ :	_____
☐	☐	Bladder & Kidney (Chronic Bladder Infections, Kidney Failure)	_____ :	_____

First Time Provider Reviewed: _____ Date: _____

Reviewed: _____ _____

_____ _____