



Concord Children's Clinic
1040 Vinehaven Drive • Concord, NC 28025

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 |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Constitutional (Unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol) |
| <input type="checkbox"/> | <input type="checkbox"/> Eyes (Cataracts, Cross Eyes) |
| <input type="checkbox"/> | <input type="checkbox"/> Ears, Nose, Mouth and Throat (Chronic Ear or Sinus Infections) |
| <input type="checkbox"/> | <input type="checkbox"/> Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack) |
| <input type="checkbox"/> | <input type="checkbox"/> Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease) |
| <input type="checkbox"/> | <input type="checkbox"/> Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems) |
| <input type="checkbox"/> | <input type="checkbox"/> Joints, Muscles, Extremities |
| <input type="checkbox"/> | <input type="checkbox"/> Skin |
| <input type="checkbox"/> | <input type="checkbox"/> Neurological System (ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's) |
| <input type="checkbox"/> | <input type="checkbox"/> Psychological or Mental Health (Depression or Anxiety) |
| <input type="checkbox"/> | <input type="checkbox"/> Endocrine (Glandular Problems, Diabetes, Thyroid Disease) |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disease (SCA, Sickle Trait) |
| <input type="checkbox"/> | <input type="checkbox"/> Immunology (Chronic Allergies, Weak Immune System) |
| <input type="checkbox"/> | <input type="checkbox"/> Bladder & Kidney (Chronic Bladder Infections, Kidney Failure) |

First Time Provider Reviewed: _____ Date: _____

Reviewed: _____

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 family? 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
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional _____ <small>(Unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes _____ <small>(Cataracts, Cross Eyes)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth and Throat _____ <small>(Chronic Ear or Sinus Infections)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels _____ <small>(Hole in Heart, Murmur, High Blood Pressure, Heart Attack)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breathing or Lung Disease _____ <small>(Asthma, Bronchitis, CF, other lung disease)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, Intestinal Tract _____ <small>(Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Joints, Muscles, Extremities _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological System _____ <small>(ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological or Mental Health _____ <small>(Depression or Anxiety)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine _____ <small>(Glandular Problems, Diabetes, Thyroid Disease)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease _____ <small>(SCA, Sickle Trait)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Immunology _____ <small>(Chronic Allergies, Weak Immune System)</small>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Kidney _____ <small>(Chronic Bladder Infections, Kidney Failure)</small>	_____

First Time Provider Reviewed: _____ Date: _____
 Reviewed: _____