Concord Children's Clinic
1040 Vinehaven Drive · Concord NC 28025
Phone: 704-784-1010 · Fax: 704-784-1013

NEW PATIENT HISTORY FORM

Patient Name _____ Date of Birth _____

Name Parent or Guardian _____ Today's Date _____

CHILDS HISTORY

Describe your child's health: _____

Birth Weight: _____ Complications at Birth: _____

Current Medications: _____

Drug Allergies: _____

Hospitalizations & Surgery: _____

_____

Extended Illness: _____

Significant Injuries: _____

Chicken Pox: ☐ Yes ☐ No Immunizations Current: ☐ Yes ☐ No

Describe Your Child's Growth: _____

Describe Your Child's Development: _____

Describe Your Child's Temperament: _____

_____

Current School: _____ Current Grade: _____

Educational & Academic History: _____

REVIEW OF SYSTEMS *(check "Problem" or "No Problem")*

Problems	No Problems	
☐	☐	Constitutional (unexplained ill feelings, fevers, weight loss, Cancer, Leukemia, High Cholesterol)
☐	☐	Eyes (Cataracts, Cross Eyes)
☐	☐	Ears, Nose, Mouth & Throat (Chronic Ear or Sinus Infections)
☐	☐	Heart & Blood Vessels (Hold in Heart, Murmur, High Blood Pressure, Heart Attack)
☐	☐	Breathing or Lunch Disease (Asthma, Bronchitis, CF, other lung disease)
☐	☐	Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)
☐	☐	Joints, Muscles, Extremities
☐	☐	Skin issues
☐	☐	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, Sickel Trait)
☐	☐	Immunology (Chronic Allergies, Weak Immune System)
☐	☐	Bladder & Kidney (Chronic Bladder Infections, Kidney Failure)

SOCIAL HISTORY

Mother's Name: _____ Occupation: _____ DOB: _____

Father's Name: _____ Occupation: _____ DOB: _____

Siblings: Name: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Marital Status of parents: _____ Child lives with: _____

List any family circumstances we should know about: _____

Smokers in family? ☐ Yes ☐ No Who? _____

Firearms in the house? ☐ Yes ☐ No Who? _____

Pets in the house? ☐ Yes ☐ No Describe: _____

Smoke detectors in the house? ☐ Yes ☐ No Religious Preference: _____

FAMILY HISTORY

Family includes: the child's parents, brothers, sisters, grandparents (maternal & paternal), aunts & uncles.
Please check "Problems or "No Problems". If there is a problem, fill out who has the condition and what the condition is.

Problems	No Problems	Who	What Condition
☐	☐	Constitutional (unexplained ill feelings, fevers, weight loss, Cancer, Leukemia, High Cholesterol)	
☐	☐	Eyes (Cataracts, Cross Eyes)	
☐	☐	Ears, Nose, Mouth & Throat (Chronic Ear or Sinus Infections)	
☐	☐	Heart & Blood Vessels (Hold in Heart, Murmur, High Blood Pressure, Heart Attack)	
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☐	☐	Neurological System (ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)	
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☐	☐	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)	
☐	☐	Blood Disease (SCA, Sickel Trait)	
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Provider Signature: _____ Date: _____