SHOALS
Family Medicine

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New Patient History Form
Birth to 5 years

Child's Full Name: ____
First Middle Last

Birth Date: ___/___/___ Age: ____ years Gender: Male ___ Female ___ Today's Date: _________

Child is presently living with the following people [check (√) all that applies]:

___ natural mother ___ natural father ___ stepmother ___ stepfather
___ adoptive mother ___ adoptive father ___ foster mother ___ foster father
___ grandmother ___ grandfather ___ split time between 2 homes
___ other (specify)

Where does this child live (circle one)?: house apartment trailer other (describe)

Are there any pets in the home? No ___ Yes ___
Are there any smokers in the home? No ___ Yes ___
Does your child stay at a daycare center or baby-sitter's? No ___ Yes ___
Does the home have air conditioning? Yes ___ No ___

Parents' History

Mother

Name ______________________________ Age ____ yr. Natural ___ Step ___ Other _____
Occupation ___________________________ Highest grade completed in school ________
Any health problems? No ___ Yes ___ (if yes, describe):

Father

Name ______________________________ Age ____ yr. Natural ___ Step ___ Other _____
Occupation ___________________________ Highest grade completed in school ________
Any health problems? No ___ Yes ___ (if yes, describe):

Brothers & Sisters names	Date of birth	Gender (circle)	Lives at home (circle)
1.		M F	No Yes
2.		M F	No Yes
3.		M F	No Yes
4.		M F	No Yes
5.		M F	No Yes

Child's Medical History

Mother's Pregnancy (check any of the following that happened during the pregnancy)

Any illnesses? No ___ Yes ___
Any smoking? No ___ Yes ___
Any medications or alcohol taken? No ___ Yes ___

Newborn & Infancy Period

Child was born: on time ___ early ___ late ___ birth weight: _____ lb. _____ oz. (or ______ gm)
Delivery was: vaginal ___ c/section ___ Number days infant was in the hospital after birth? ____
Any problems during the delivery? No ___ Yes ___
Any problems during the first days after birth? No ___ Yes ___
If yes, please list the problems:

Present Medical Condition

1. Does your child have any vision or hearing problems? No ___ Yes ___
2. Is your child being treated for any illnesses currently? No ___ Yes ___
   If yes, please list:
3. Is your child taking any medications currently? No ___ Yes ___
   If yes, please list:

Does your child see any specialists at the current time? No ___ Yes ___

Has this child had any of the following problems?

Problem	No	Yes	If yes, please describe
Allergies to food or medicines?			
Anemia (low blood count)?			
Broken bones?			
Colic or extreme fussiness?			
Convulsions (seizures)?			
Difficulty feeding or picky eater?			
Fainting spells?			
Frequent or recurrent infections?			
Head injuries or knocked unconscious?			
Hospital stays overnight?			
Operations (surgeries)?			
Sleep problems?			
Wheezing or asthma?			
Any other serious illness?			

Developmental History {check (√) all of the acts that your child can do & write the age it first happened}

Action (children under 2 years)	√	Age
Smiles at you		
Laughs out loud		
Coos & gurgles		
Turns toward interesting sounds		
Grasps an object with hand		
Rolls over both ways		
Sits up by self		
Crawls		
Pulls up to a standing position		
Walks down side of furniture		
Took first steps without holding on		

Action (children 2 years & older)	√	Age
Took first steps without holding on		
Said first words		
Recognized his/her own name		
Starting running		
Walks up steps by self		
Talked in sentences		
Potty trained		
Pedaled a tricycle		
Dresses self with little help		
Reads a book by self		
Rides a bicycle		

Family History [Has anyone in your family had any of the following problems? If so, place a check mark (√) in the column underneath all family members who have the problem.]

Problem	Mother	Father	Brother(s)	Sister(s)	Grand-parent	Uncle or Aunt	Other family member
ADHD or learning problems							
Allergies							
Anemia (low blood count)							
Asthma							
Cancer (including leukemia)							
Cystic fibrosis							
Diabetes							
Eye problems or poor vision							
Hearing problems or deafness							
Heart attack that occurred < 55 yrs							
High blood pressure							
High cholesterol in blood							
Kidney or bladder problems							
Mental health problems							
Mental retardation							
Migraine headaches							
Seizures or epilepsy							
Sickle cell disease							
Skin problems							
Stroke that occurred < 55 yrs							
Thyroid disease							
Tuberculosis (TB)							

Reviewed by: ______________________________, M.D.