StoneBrooke family physicians

New Patient History
Birth to 11 Years Old

Patient Name: _____

DOB: _____ Date: _____

MEDICAL HISTORY

Has your child had any of the following medical problems?

☐ Allergies	☐ Constipation	☐ Joint Pain	**Please list any other medical conditions that your child has had**
☐ Anemia	☐ Diarrhea	☐ Nervousness	☐
☐ Asthma	☐ Depression	☐ Frequent Respiratory Infection	☐
☐ Poor Vision	☐ Frequent Ear Infection	☐ Seizures	☐
☐ Broken Bones	☐ Headaches	☐ Weight loss	☐
☐ Chicken Pox	☐ Heart Murmur		☐

CURRENT MEDICATIONS

☐ See List

MEDICATION NAME	DOSE	DIRECTION

DRUG ALLERGIES

☐ No Drug Allergies

MEDICATION	REACTION

FAMILY HISTORY

Please list any family members in your ***IMMEDIATE*** family with any of the following medical issues		LIVING? YES OR NO **(If deceased, what age)**
Hypertension (high blood pressure)		
Hypercholesterolemia (high cholesterol)		
Diabetes		
Heart Disease/Heart Attack		
Cancer and Type		
Other:		

SOCIAL HISTORY

How many people live in this child's household? _____

Does anyone smoke in the household/daycare? Yes ☐ No ☐

Is your child in daycare? Yes ☐ No ☐

BIRTH HISTORY

Were there any complications during the pregnancy (Gestational diabetes, high blood pressure, infections, toxemia)?

_____

Full term delivery? ☐ Yes ☐ No

How many weeks gestation? _____

Vaginal delivery or C-Section? _____

Did your child need any special care or medications after birth?

_____

SURGERIES/OPERATION

DATE	SURGERY/OPERATION