Patient Name:	
Current Medications (Including Supplements, Vitamins):	
Allergies to Medications?	
Food Allergies?	
Which pharmacy do you prefer?	

Birth History

Was your child born premature?		NICU Stay?	
What was your child's birth weight?		Complications after delivery?	

Health History

Has your child had any of the following conditions currently or in the past?

☐ Asthma ☐ Heart Murmur ☐ Concussion

☐ Bladder/ Urine Infection ☐ Diabetes ☐ Bleeding Disorder

☐ Thyroid ☐ Fractures ☐ Other: _____

☐ Eczema ☐ Migraines

Has your child ever been hospitalized? (If yes, explain)

_____

Has your child ever had surgery? (If yes, explain)

_____

Are your child's immunizations up to date? Yes No

Does your child attend school/ day care? Yes No

Who provides after-school monitoring? _____

What grade is your child in? _____

Who was your child's previous Pediatrician? _____

Family Medical and Social History

Do the child's mother, father, siblings, or grandparents have any of the following? If yes, who?

Yes No	High Blood Pressure	
Yes No	Thyroid	
Yes No	Diabetes	
Yes No	Lung Problems (Asthma)	
Yes No	Heart Problems	
Yes No	Mental Illness (Depression)	
Yes No	Hepatitis	
Yes No	TB	
Yes No	HIV	
Yes No	Migraines	
Yes No	Bleeding Disorder	
Yes No	Smoker	
Yes No	Alcohol Use	
Yes No	Drug Use	
Yes No	Cancer	

Who lives in the home? _____

List the names of siblings, if any. _____

Does your child participate in extracurricular activities (sports, clubs, or dance)? Yes No

Please circle all that apply:

Do you have concerns about your child's?

Hearing Vision Speech Development School Performance

Please list any health concerns you may have concerning your child:

_____

_____

_____

_____

Thank you for choosing NeoHealth Pediatrics! Your child's health is important to us!