CHILDREN FIRST PEDIATRICS

PATIENT HISTORY FORM

☐ Dr. Koch ☐ Dr. Applegate

Name: _____ Sex M F Date of Birth _____/_____/_____

Address: _____

_____

	Name	Birthdate	Lives with child
Mother	_____	_____	☐
Father	_____	_____	☐
Siblings	_____	_____	☐
	_____	_____	☐
	_____	_____	☐

Patient Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic, Not Latino
☐ Prefer not to report

Patient Race: ☐ American Indian or Alaskan
☐ Asian
☐ Black or African American
☐ Caucasian or White
☐ Eastern European
☐ Middle Eastern
☐ Other _____
☐ Prefer not to report

Primary language in home: ☐ English
If other please list:_____

PARENT HEALTH HISTORY

	Father	Mother		Father	Mother		Father	Mother
Asthma	☐	☐	Mental Retardation	☐	☐	Thyroid Dysfunction	☐	☐
Allergies	☐	☐	Reflux Esophagitis	☐	☐	Scoliosis	☐	☐
Birth Defect	☐	☐	Congenital Heart Defect	☐	☐	Eczema	☐	☐
Heart Condition	☐	☐	Diabetes	☐	☐	Psychiatric Issues	☐	☐
High Blood Pressure	☐	☐	Cancer	☐	☐	Other (list)_____		
High Cholesterol	☐	☐	Migraine Headaches	☐	☐			

Patient Current Medications:

List all allergies for patient:

PREGNANCY AND INFANT HISTORY

Illness during Pregnancy Yes No Type _____

Weeks Gestation _____

Birth Hospital _____

Birth Weight _____

Problems in Hospital _____

Delivery Method: ☐ Vaginal ☐C-Section

Breech? ☐Yes ☐No

Feeding: ☐ Breast ☐ Formula ☐ Both

Any doctor ever told you that the patient had a developmental delay? ☐ No ☐ Yes If yes, what delay? _____

PATIENT PAST HEALTH HISTORY

	Yes	No		Yes	No
More than 2 ear infections in past year	☐	☐	Vision Problems	☐	☐
Wheezing	☐	☐	Hearing Problems	☐	☐
Pneumonia (if yes dates: _____)	☐	☐	Trauma	☐	☐
Chicken Pox (had the disease)	☐	☐	Other_____	☐	☐
Croup (dates: _____)	☐	☐	Immunizations Up-to-date	☐	☐
Mononucleosis (date:_____)	☐	☐	Hospitalizations (list dates and conditions)		
Urination Problems	☐	☐			
Febrile Seizures (date:_____)	☐	☐	Surgeries (list dates and surgeries)		

Any other issues you would like us to know about?

Person completing form: _____ Relationship: _____