Hand In Hand Pediatrics
Patient History Form

Welcome to Hand In Hand Pediatrics! Please fill out this form as much as possible.

Patient Name _____ Birth Date _____

Person completing this form _____ Relationship _____

Birth History

Is the child yours by: birth ☐ adoption ☐ stepchild ☐ other ☐

Gestational age at birth _____ Birth weight _____ Birth Length _____

Birth Hospital _____ Hepatitis B vaccine? Yes ☐ No ☐ Date _____

Apgars score _____ Newborn hearing screen pass ☐ not pass ☐

Delivered by vaginal ☐ c-section ☐ Reason for c-section _____

Complications during newborn hospitalization _____
_____

Family History

Please check all categories that apply and which family member has had the diagnosis. Please include parents, grandparents, siblings, and parents' brothers and sisters. Please mark all that apply.

Condition	None	Biological Mother	Biological Father	Sibling	Grandparent	Other
Asthma	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Bleeding/Clotting Disorder _____	☐	☐	☐	☐	☐	☐
Cancer Type _____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Gastrointestinal	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐
Heart Attack <50 yrs	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Psychological ADHD, autism, anxiety _____	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐

Please explain all positives _____
_____

Patient Name _____ Birth Date _____

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	Yes	No	
Asthma/wheezing/pneumonia	☐	☐	_____
Allergies- food/pets/seasonal	☐	☐	_____
Anemia/blood disorder	☐	☐	_____
Diabetes	☐	☐	_____
Ear infections/strep throat	☐	☐	_____
Genetic disorder	☐	☐	_____
Heart disease/defects	☐	☐	_____
Intestinal problems	☐	☐	_____
Neurological (headaches/seizures)	☐	☐	_____
Psychological (ADHD, autism, anxiety)	☐	☐	_____
Urinary tract infections/disorders	☐	☐	_____
Other chronic conditions	☐	☐	_____

Has your child ever been hospitalized overnight? Yes ☐ No ☐ Please explain and give dates _____

_____

Please list any specialist(s) your child is seeing _____

_____

Medications

Allergies to medications and reactions _____

Current medications and dose _____

_____

_____

Vitamins, herbal supplements, over the counter medications_____

_____

Surgical History

Type of surgery and date of surgery _____

Social History

Who lives in the household with your child? Parent ☐ Parent ☐ Siblings ☐ #_____ Other ☐

Parent(s) Married☐ Single ☐ Divorced ☐ Remarried ☐ Name of Step-parent _____

Custody ☐ (Please bring in custody papers if other than shared)

Smokers Yes No Pets Yes No What kind?_____ Age of home _____

Does your child stay home with you? Yes No Does your child attend daycare/preschool/babysitter? Yes No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school _____

_____ _____

Reviewed by Physician