

NEW PATIENT - HEALTH BACKGROUND

Childs Name: _____

Date: _____

Date of Birth: _____

Does the child have any chronic health problems? (Please List)

Allergies ? (Please list, Including Asthma, Hay / Fever, Food and Medication Allergies).

Has the child ever been hospitalized? (Please list reason and appropriate date).

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is the child on medication all the time? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the child on a special diet? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has he / she had any surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the child have any developmental delay? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a family history of any diseases or genetic problems or require special education? |
| <input type="checkbox"/> | <input type="checkbox"/> | Was your house / apartment built before 1960? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on a (fluoridated) City water supply? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the child participate in organized sports? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there any serious behavioral problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any major concerns? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are immunizations up to date? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has child had Chicken Pox? |