Banner Health

NEW PATIENT MEDICAL HISTORY
(0-17 YEARS)

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Parent Occupation: _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Previous Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Maternal and Birth History
(Complete if under 2 years old)

Maternal Age: _____ Prenatal Care: Y / N Full Term _____ Premature _____

weeks gestation (how far along were you?): _____ # of pregnancies: _____ # of births: _____

Complications during pregnancy? Yes ____ No ____ If yes, please explain _____

Type of delivery: Normal Vaginal ____ C-Section ____ Repeat C-Section ____ Emergent C-Section (Reason) _____

Patient Adopted _____ If yes, Birth Country: _____

Birth Weight: _____ lbs. _____ oz. Length: _____ Head Circumference: _____ inches Time of Birth: _____

Birth Hospital: _____

Jaundice: Y / N Oxygen Required: Y / N Stayed in NICU: Y / N

Feeding: Breast / Bottle / Both Number of feeds/day: _____ Type of Formula: _____

Received Hepatitis B vaccine at birth? ❑ Yes ❑ No

Passed hearing screen? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.**

❑ **No known allergies**

Allergy:	**Reaction:**

MEDICATIONS

❑ **List any medications you are taking, including vitamins and over the counter. List dose and how often.**

Medication Name:	**Dose:**	**How often?**	**Refill needed (Y/N)?**

Immunizations

Immunization History Unknown _____ Immunization record brought in today _____ No immunizations by choice _____

Has patient ever lived or traveled outside the U.S? ❑ Yes ❑ No If yes, where? _____

Has patient ever had a positive tuberculosis / PPD test? ❑ Yes ❑ No

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0117
(08/2018)

Banner Health

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Patient Name: _____ Date of Birth: _____

Patient Medical History

List any current or past medical conditions (please place checkmark by any current problems).

❑ **No Medical History**

Surgeries and/or Hospitalizations

Has your child had any surgeries or has been hospitalized? (provide dates and reason below)

❑ **No Surgeries or Hospitalizations**

Date:	Reason:	Date:	Reason:

Has your child had any reactions to anesthesia? ❑ Yes ❑ No If yes, explain: _____

_____

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

Dental History

(For 12 months and older)

Name of your child's dentist and date of last visit: _____

Social History

Patient lives with (please indicate all)

❑ Mother Name: _____ Date of birth: _____

❑ Step-Father Name: _____ Date of birth: _____

❑ Father Name: _____ Date of birth: _____

❑ Step-Mother Name: _____ Date of birth: _____

❑ Other (Please Specify) Name(s): _____ Relationship _____

Siblings Name/Age:

_____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____

Child attends daycare: ❑ Yes ❑ No

Pets in Household: ❑ Yes ❑ No If yes, list all pets: _____

Smokers in household: ❑ Yes ❑ No If yes, list: _____

Does your child use a seat belt or car seat? ❑ Yes ❑ No

Does your child use a helmet when riding a bicycle? ❑ Yes ❑ No

Do you have firearms in the home? If yes, are they locked up? ❑ Yes ❑ No

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Patient Name: _____ Date of Birth: _____

Review of Systems

Does the patient currently have or in the past had problems related to the following?

Weight gain	Y / N	Fever	Y / N	Scrotum testicular mass	Y / N	Skin itching	Y / N
Weight loss	Y / N	Fainting	Y / N	Painful bleeding	Y / N	Skin lesion	Y / N
Chills	Y / N	Diarrhea	Y / N	Heavy menstrual bleeding	Y / N	Bone pain	Y / N
Dizzy	Y / N	Heartburn	Y / N	Excessive thirst	Y / N	Joint pain	Y / N
Trouble swallowing	Y / N	Vomiting	Y / N	Frequent urination	Y / N	Joint swelling	Y / N
Vision loss	Y / N	Runny nose	Y / N	Scrotum testicular mass	Y / N	Swollen lymph nodes	Y / N
Shortness of breath	Y / N	Allergic rash	Y / N	Distorted body image	Y / N	Red spots	Y / N
Wheezing	Y / N	Penile discharge	Y / N	Self-conscious	Y / N	Bleeding disorders	Y / N
Chest pain	Y / N	Heart murmur	Y / N	Heart condition	Y / N	Known TB exposure	Y / N

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