FAMILY PHYSICIANS OF GREELEY, PLLP

Child Health History for New Patient

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Preferred Pharmacy (name and location): _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill out all pages. If you cannot remember specific details, please provide your best guess.

Medications

Please list all prescription and non-prescription medications, vitamins, and any supplements that you take, even on a non-regular basis.

Medication	Dosage	Times per day

Allergies

Please list all allergies to medications, latex, shellfish or iodine.

Allergies	Known Side Effects or Reactions

Personal Medical History

Condition	Current	Past	Comments
ADD/ADHD			
Allergies			
Acne			
Anemia			
Asthma			
Bleeding Disorder			
Birth Trauma			
Bronchitis			
Chicken Pox			
Concussion			
Congenital Heart Disease			
Constipation			
Diabetes			
Eczema			
Fractures (Broken Bones)			
GERD/Heartburn			
Headaches/Migraines			
Head Injury			
Hearing Issues			
Heart Murmur			
Kidney Infections			
Menstrual Issues			
Pneumonia			
Prematurity			
Recurrent Ear Infections			
Recurrent Urinary Tract Infections			
RSV			
Seizure Disorder			
Other:			
Other:			
Other:			

Surgical History

Procedure	Yes	Year	Comments
Adenoidectomy			
Appendectomy (Appendix Removal)			
Dental Surgery			
Ear Tube Placement			
Fracture with Surgical Repair			
Hernia Repair			Circle: Inguinal / Umbilical
Lymph Node Biopsy			
Tonsillectomy			
Other:			
Other:			
Other:			

Family History

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative:	Comments
No Significant History Known										
ADD/ADHD										
Alcoholism/Drug Abuse										
Allergies										
Alzheimer's										
Anxiety										
Asthma										
Arthritis										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Blood Disease (Please List)										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Prostate										
Cancer, Other										
Colon Polyps										
COPD/Emphysema										
Coronary Artery Disease										
Depression										
Developmental Delay										
Diabetes										
Genetic Disorders (Explain)										
Glaucoma										
Heart Disease										
Hearing Disease										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hip Fracture										
Kidney Disease										
Kidney Stones										
Learning Disabilities										
Migraine Headaches										
Mental Illness										
Obesity										
Osteoporosis										
Seizure Disorder										
Skin Conditions (Please List)										
Stroke										
Thyroid Disease										
Other:										
Other:										
Other:										

Immunizations

Has the child been immunized? ☐ No ☐ Yes

If yes, where are the immunization records? _____

Social History

Father/Guardian's name: _____ Relationship to child: _____

Occupation: _____ Contact number: _____

Mother/Guardian's name: _____ Relationship to child: _____

Occupation: _____ Contact number: _____

Child resides with: _____

Child Care (day care, sitter, nanny, grandparents): _____ Hours/week: _____

School name: _____ Grade: _____

Overall performance in school: ☐ Below grade level ☐ At grade level ☐ Above grade level

Learning Disabilities ☐ No ☐ Yes

Special Needs ☐ No ☐ Yes

Gifted Program ☐ No ☐ Yes

Sleep:

Takes naps ☐ No ☐ Yes

Sleeps through the night ☐ No ☐ Yes

Minimum 8 hours of sleep ☐ No ☐ Yes

Sleeps with parents ☐ No ☐ Yes

Nightmares/sleep problems ☐ No ☐ Yes

Safety:

Uses bike/skating helmet ☐ No ☐ Yes

Car restraint (car seat/booster/seat belt) ☐ No ☐ Yes

Carbon monoxide detector in home ☐ No ☐ Yes

Smoke detector in home ☐ No ☐ Yes

Radon in home ☐ No ☐ Yes

Tobacco Exposure:

Smokers in the home ☐ No ☐ Yes

Age 13 and Older

Tobacco Use:

Smoke Cigarettes? ☐ Never ☐ Former ☐ Yes

Other Tobacco: ☐ Vapor ☐ Hookah ☐ Snuff ☐ Chew

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes

Number of drinks/week: _____

Type: ☐ Beer ☐ Wine ☐ Liquor

Caffeine Use:

Do you use caffeine? ☐ No ☐ Yes

Number of drinks/day: _____

Type: ☐ Chocolate ☐ Coffee/Tea ☐ Energy Drinks ☐ Soda

Drug Use:

Do you use marijuana or recreational drugs? ☐ No ☐ Yes

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity:

Sexually involved currently? ☐ No ☐ Yes

Sexual partner(s) is/are/have been: ☐ Male ☐ Female

History of STDs: ☐ No ☐ Yes, type: _____

Birth control method: ☐ None ☐ Condom ☐ Pill ☐ IUD ☐ Nexplanon

☐ Other: _____

For Females:

Total number of pregnancies: _____ Number of births: _____

Age at beginning of periods (menstruation): _____

Date (month/date if known) of last menstrual period: _____ How long do they last? _____ days

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (HIPAA)
Family Physicians of Greeley, PLLP

Name: _____ **Date of Birth:** _____
Name of Patient or Guardian

Release of Information

☐ I authorize Family Physicians of Greeley, its employees and agents to disclose my health information, including my visit records, diagnoses, treatments and test results, to the person(s) identified below. I understand that any personal health information released to the person(s) identified may be subject to re-disclosure by such person and may no longer be protected by applicable federal and state privacy laws.

This information may be released to:

☐ Spouse: _____

☐ Child[ren]: _____

☐ Other: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

I understand that I have a right to revoke this authorization by providing written notice to Family Physicians of Greeley. However, this authorization may not be revoked if Family Physicians of Greeley, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for healthcare services.

Messages

Please call: ☐ my home: _____ ☐ my work: _____

☐ my cell phone: _____ ☐ other: _____

If unable to reach me: ☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (*days*) _____, between (*time*)_____

Signed: _____ Date: _____

Witness: _____ Date: _____