

Established Patient History Update

Patient Name: _____ DOB: _____ Form filled out by: Mom Dad Guardian Other: _____

Birth History <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Birth weight: _____ <input type="checkbox"/> Preterm _____ wks. <input type="checkbox"/> NICU stay _____ wks			
Any delivery complications or birth defects? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____			
Child went home with Mom/Parents <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Went to foster care <input type="checkbox"/> Went for adoption			
Have your child had any of the following:	No	Yes	If yes, please describe:
Traumatic Brain Injury?			
Chronic medical conditions i.e., allergies, asthma, eczema, constipation, bedwetting, obesity, diabetes, thyroid problems, heart problems, seizures, migraine headaches, malignancy, sickle cell disease or trait, etc.?			
Developmental or Speech delay/Autism/ Cerebral palsy?			
Vision or hearing problems?			
Overnight hospital stay?			
Surgery?			
Mental health problems i.e. ADHD, Anxiety, Anger, depression, Bipolar, suicidal behavior?			
Substance abuse issues?			
Participates in sports & extracurricular activities?			
Taking any medication now?			
Any known allergies?			

Family history: Do the biological parents, grandparents, aunts, uncles, cousins have:

Mental health problems i.e. ADHD, Anxiety, Bipolar disorder, Substance abuse, Suicidal behavior			
Chronic medical conditions i.e. allergies, asthma, eczema, constipation, diabetes, thyroid problems, obesity, heart problems, seizures, migraine headaches, malignancy, sickle cell disease or trait, etc?			
Sudden death in young age			

Social determinants of health:

Child lives with: <input type="checkbox"/> Parents <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other: _____
Child is in: <input type="checkbox"/> Day Care <input type="checkbox"/> School Grade: _____ <input type="checkbox"/> Home School Grade: _____
Any guns at home: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Decline to Answer If yes, is it secured? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was the child ever been removed from home? <input type="checkbox"/> No <input type="checkbox"/> Yes
For the statements below please indicate if it applies to your household for the past 12 months?
1. "We worried whether our food would run out before we got money to buy more." <input type="checkbox"/> Often True <input type="checkbox"/> Sometimes True <input type="checkbox"/> Never True <input type="checkbox"/> Decline to Answer
2. "The food that we brought just didn't last, and we didn't have money to get more." <input type="checkbox"/> Often True <input type="checkbox"/> Sometimes True <input type="checkbox"/> Never True <input type="checkbox"/> Decline to Answer