FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Pediatric Patient History Form

Name: _____ Date: _____

Gender: _____ Date of Birth: _____ Age:_____ Parents: _____

What name would you like to be called? _____

How were you referred to Family First? _____

Please briefly state reason for visit: _____

TELL US ABOUT YOURSELF:

School currently attending: _____ Grade in school: _____

Who lives in your household? _____

Siblings: Yes or No How many: _____ Are they healthy?_____

Does anyone in the household smoke? _____

Pets: _____ Sports/extracurricular activities: _____

Do you exercise? Yes or No If yes, what type and how often? _____

How is your diet? _____

OTHER HEALTH CARE PROVIDERS:

Do you see a dentist? Yes or No Last visit date: _____

Do you see an eye doctor? Yes or No Last visit date: _____

Do you see any other physicians or other health providers? Yes or No (If yes, please provide details)

Name: _____ Date of Last Visit: _____
Reason: _____

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Reason: _____

BIRTH HISTORY:

Where were you born? (City and hospital) _____

Birth weight: _____ Type of delivery (choose one): Vaginal C-Section VBAC Forceps Vacuum

How many weeks gestation? _____ If premature, how long in NICU?_____

Any problems or complications during pregnancy or delivery?_____

Were you breastfed and for how long?_____

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IMMUNIZATIONS:

Up to date? **Yes or No** Any adverse reactions? If yes, please explain. _____

FEMALES ONLY (If applicable)

Age Menstrual Periods Began: _____ First Day of Last Menstrual Period: _____

If your periods have begun, do you have one every month? Yes or No If not, how often? _____

How many days do you bleed? _____ Menstrual Flow: (circle) Light Moderate Heavy Pain with Periods: Yes or No

PAST OR PRESENT DISEASES OR SERIOUS ILLNESSES:

_____

_____

SURGERIES or HOSPITALIZATIONS:

_____

ALLERGIES OR ADVERSE DRUG REACTIONS?

_____

MEDICATIONS:

_____

NON-PRESCRIPTION: (over-the-counter medications, vitamins, laxatives, supplements, herbals, homeopathy, etc.)

_____

FAMILY HISTORY:

Have any of your immediate family members (e.g. parents, siblings, grandparents) had any of the following conditions?

Illness/Condition	Yes	No	Relationship to Patient	Illness/Condition	Yes	No	Relationship to Patient
Cancer				Thyroid disease			
Heart disease/heart attack				Depression/anxiety			
Stroke				Mental illness			
High blood pressure				Autoimmune disease			
High cholesterol				Other: (please list)			
Diabetes							
Sudden death before age 60?							