

ALCAMS

New Patient History Form

Birth to 5 years

Child's Full Name: _____
First Middle Last

Birth Date: ___ / ___ / ___ Age: ___ years Gender: Male ___ Female ___ Today's Date: _____

Child is presently living with the following people [check (√) all that applies]:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> natural mother | <input type="checkbox"/> natural father | <input type="checkbox"/> stepmother | <input type="checkbox"/> stepfather |
| <input type="checkbox"/> adoptive mother | <input type="checkbox"/> adoptive father | <input type="checkbox"/> foster mother | <input type="checkbox"/> foster father |
| <input type="checkbox"/> grandmother | <input type="checkbox"/> grandfather | <input type="checkbox"/> split time between 2 homes | |
| <input type="checkbox"/> other (specify) | | | |

Where does this child live (circle one)?: house apartment trailer other (describe)

- | | |
|--|----------------|
| Are there any pets in the home? | No ___ Yes ___ |
| Are there any smokers in the home? | No ___ Yes ___ |
| Does your child stay at a daycare center or baby-sitter's? | No ___ Yes ___ |
| Does the home have air conditioning? | Yes ___ No ___ |

Parents' History

Mother

Name _____ Age ___ yr. Natural ___ Step ___ Other ___
 Occupation _____ Highest grade completed in school _____
 Any health problems? No ___ Yes ___ (if yes, describe):

Father

Name _____ Age ___ yr. Natural ___ Step ___ Other ___
 Occupation _____ Highest grade completed in school _____
 Any health problems? No ___ Yes ___ (if yes, describe):

Brothers & Sisters names	Date of birth	Gender (circle)	Lives at home (circle)
1.		M F	No Yes
2.		M F	No Yes
3.		M F	No Yes
4.		M F	No Yes
5.		M F	No Yes

Child's Medical History

Newborn & Infancy Period

Child was born: ___ on time ___ early ___ late birth weight: _____ lb. _____ oz. (or _____ gm)
 Delivery was: ___ vaginal ___ c/section Number days infant was in the hospital after birth? ___
 Any problems during the pregnancy? No ___ Yes ___
 Any problems during the delivery? No ___ Yes ___
 Any problems during the first days after birth? No ___ Yes ___

Present Medical Condition

1. Does your child have any vision or hearing problems? No ___ Yes ___
2. Does your child have problems with bedwetting? No ___ Yes ___
3. Is your child behind on his/her vaccines? No ___ Yes ___
4. Is your child being treated for any illnesses currently? No ___ Yes ___
 If yes, please list:
5. Is your child taking any medications currently? No ___ Yes ___
 If yes, please list:

Healthcare Providers

1. Who has your child seen most recently for his/her routine healthcare visits (medical care)?
2. Does your child see any specialists at the current time? No ___ Yes ___
 If yes, list their names:

Has this child had any of the following problems?

Problem	No	Yes	If yes, please describe
Allergies to food or medicines?			
Anemia (low blood count)?			
Broken bones?			
Colic or extreme fussiness?			
Convulsions (seizures)?			
Difficulty feeding or picky eater?			
Fainting spells?			
Frequent or recurrent infections?			
Head injuries or knocked unconscious?			
Hospital stays overnight?			
Operations (surgeries)?			
Sleep problems?			
Wheezing or asthma?			
Any other serious illness?			

Developmental History {check (√) all of the acts that your child can do & write the age it first happened}

Action (children under 2 years)	√	Age	Action (children 2 years & older)	√	Age
Smiles at you			Took first steps without holding on		
Turns toward interesting sounds			Starting running		
Grasps an object with hand			Walks up steps by self		
Rolls over both ways			Talked in sentences		
Sits up by self			Potty trained		
Crawls			Pedaled a tricycle		
Pulls up to a standing position			Dresses self with little help		
Took first steps without holding on			Reads a book by self		

School History

1. Child's Current School: _____ Grade _____

Family History [Has anyone in your family had any of the following problems? If so, place a check mark (√) in the column underneath all family members who have the problem.]

Problem	Mother	Father	Brother(s)	Sister(s)	Grand-parent	Uncle or Aunt	Other family member
ADHD or learning problems							
Alcohol and/or drug abuse							
Allergies							
Anemia (low blood count)							
Asthma							
Cancer (including leukemia)							
Diabetes							
Eye problems or poor vision							
Hearing problems or deafness							
Heart attack that occurred < 55 yrs							
High blood pressure							
High cholesterol in blood							
Kidney or bladder problems							
Lung problems (including CF, TB)							
Mental health problems							
Mental retardation							
Migraine headaches							
Seizures or epilepsy							
Sickle cell disease							
Skin problems							
Stroke that occurred < 55 yrs							
Thyroid disease							

Reviewed by: _____, M.D. / NP / PA