ALCAMS
New Patient History Form
6 to 18 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]:

___ natural mother ___ natural father ___ stepmother ___ stepfather
___ adoptive mother ___ adoptive father ___ foster mother ___ foster father
___ grandmother ___ grandfather ___ split time between 2 homes
___ 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?

Problem	No	Yes	If yes, please describe
Allergies (food, pollens, dust, etc)?			
Allergies or problems with medicines?			
Anemia (low blood count)?			
Behavior problems?			
Broken bones?			
Convulsions (seizures)?			
Fainting spells?			
Frequent or recurrent infections?			
Head injuries or knocked unconscious?			
Hospital stays overnight?			
Meningitis?			
Operations (surgeries)?			
School or learning problems?			
Sleep problems?			
Wheezing or asthma?			
Any other serious illness?			

Developmental History (for children under 10 years of age, what age did your child start doing the following)

walking _____ said first words _____ talked in sentences _____
was potty trained _____ tied own shoes _____ dressed self _____
rode a bicycle _____ started reading _____

School History

1. Child's Current School: _____ Grade _____
2. Has your child ever repeated any grades? No ___ Yes ___ If yes, list grades repeated
3. Has your child been placed in any special classes? No ___ Yes ___ If yes, list the classes

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