Bainbridge Pediatrics
infancy through adolescence

Patient Health History Form

Today's Date: _____

Patient's Name: _____ Date of Birth (DOB): _____

Parent: _____ Occupation: _____ DOB: _____

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Parents: Married Divorced Separated (Circle One)

Other Caregivers: _____ Relation: _____

How did you hear about Bainbridge Pediatrics? _____

Pregnancy & Birth History

While pregnant, did mother:
Have any complications? Yes ☐ No ☐
Use alcohol, drugs or smoke? Yes ☐ No ☐
Take any medications? Yes ☐ No ☐
Length of Pregnancy: _____ weeks
Type of Delivery: _____
Birth Weight: _____ lbs. _____ oz.
Newborn Hearing Screen Passed? Yes ☐ No ☐
Delivered at: _____
Name of Hospital

Child's Current Health

Is your child taking prescription or over the counter medications (i.e. vitamins)? Yes ☐ No ☐
Name of Medications: _____
_____
Any allergies to Medications? Yes ☐ No ☐
Please List: _____
_____
Your Child's Dentist: _____
Any Dental Problems? Yes ☐ No ☐
Please List: _____

Child's Health History

Hospitalizations: Yes ☐ No ☐
Illness: _____ Date: _____
Surgeries: Yes ☐ No ☐
Procedure: _____ Date: _____
Injuries/Fractures: _____ Yes ☐ No ☐
Hearing Problems: _____ Yes ☐ No ☐
Vision Problems: _____ Yes ☐ No ☐
Ear/Nose/Throat Problems: _____ Yes ☐ No ☐
Asthma: _____ Yes ☐ No ☐
Hay Fever or Allergies: _____ Yes ☐ No ☐

Diabetes/Thyroid Problems: _____ Yes ☐ No ☐
Kidney Problems: _____ Yes ☐ No ☐
Cardiac Conditions: _____ Yes ☐ No ☐
Respiratory Problems: _____ Yes ☐ No ☐
Gastro/Intestinal Problems: _____ Yes ☐ No ☐
Migraines or Head Aches: _____ Yes ☐ No ☐
Anemia/Low Iron: _____ Yes ☐ No ☐
ADHD: _____ Yes ☐ No ☐
Learning Disability: _____ Yes ☐ No ☐
Scoliosis: _____ Yes ☐ No ☐

Family Health History

Parental Height: Mother: _____ Father: _____
Have any close ***family*** members (**parents, grandparents & siblings**) had any of the following (**State Whom**):

Hearing Problems: _____
Vision Problems/Lazy Eye: _____
Asthma: _____
Hay Fever or Allergies: _____
Heart Disease Prior to Age 50 years: _____
High Blood Pressure: _____
Elevated Cholesterol: _____
Diabetes: _____
Thyroid Disease: _____
Kidney Disease: _____
Epilepsy (Seizures): _____

Cancer (type): _____
Liver Disease: _____
Bleeding Disorder/Blood Clots: _____
Smokers: _____
Alcohol or Drug Abuse: _____
Depression or Mental Illness: _____
ADHD: _____
Learning Disability: _____
Scoliosis: _____
Migraines or Head Aches: _____
Other: _____