Trinity Health

IHA Medical Group

New Patient History Form – Pediatrics

Patient Name: _____ **Date of Birth:** _____
Siblings & Dates of Birth :_____

Parent/Guardian 1 Name:_____ Occupation:_____
Phone Number:_____
Address: _____

Parent/Guardian 2 Name:_____ Occupation:_____
Phone Number:_____
Address: _____

Patient lives with: _____

Parent/Guardian Relationship (Check all that apply):

☐ Married ☐ Living together ☐ Same-sex couple ☐ Never together ☐ Separated
☐ Divorced ☐ Single parent ☐ Guardian/Foster parent ☐ Father not involved
☐ Mother not involved

Do you have working smoke detectors in your home? Yes/No
Do you have working carbon monoxide detectors in your home? Yes/No
Does this child reside in or regularly visit a home/residential building, childcare setting, school, or other facility built before 1978? Yes/No
Does anyone in the home smoke or vape? Yes/No
If you have firearms in the home or car, are they all secured with a locking device or in a safe? Yes/No/NA

Active or Chronic Problems (check all that apply for this patient or list below):

☐ ADD/ADHD	☐ DDH – hip dysplasia	☐ Diabetes	☐ Autism
☐ Food Allergies	☐ Hearing Impairment	☐ Ear Infections	☐ Mental Illness
☐ Asthma	☐ Depression/Anxiety	☐ Eczema	☐ Migraines/Headaches
☐ Cancer	☐ Developmental Delay	☐ Elevated Cholesterol	☐ Heart Disease
☐ Seizures	☐ Seasonal Allergies	☐ Sickle Cell	☐ Scoliosis

Please list other Active or Chronic Problems:

_____

Past Surgery: _____ Year_____

_____ Year_____

PLEASE TURN OVER

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Please list other pertinent information we should know, including other doctors, specialists or mental health providers your child sees:

_____

Patient's Medication Allergies & Reaction:

_____

Current Medications – Please list all over the counter medications, supplements, herbal medications and/or any medications prescribed by previous doctor or specialist patient is currently taking

Medication	Dosage	Times per Day	Prescribed by

Please list any significant medical conditions in the patient's biological family (parents, siblings, grandparents).

If this information is not available, or if the patient is adopted, please check here: ☐

	Mother	Father	Sibling	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
ADD/ADHD								
Asthma								
Anxiety								
Autism								
Cancer-type								
Deafness								
Depression								
Development Delay								
Diabetes								
Elevated cholesterol								
High Blood Pressure								
Migraines								
Seizures/Epilepsy								
Sickle Cell								
Sudden death<55yr								
Thyroid								
Other- specify								