Cheryl Newman M.D.
Family Medicine

Child History

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Name_____ Age:_____ D.O.B. ___/___/___

Most recent Primary Care Provider:_____

Please list any concerns you want to discuss with Dr. Newman

Health History

Please list your child's current medical problems

Please list any past medical problems:

Please list ALL of the medications child takes:
(Please include prescription drugs, home remedies, over-the-counter medications, allergy or cold pills, laxatives, and vitamins. If you do not have enough room, please use another sheet of paper.)

Name Dose (mg or # of pills) How many times a day?

Is your child allergic to any medications? _____ Reaction?_____
Is your child allergic to anything else?_____

Please list all of the other doctors your child has seen. Please include dentists, eye doctors, chiropractors, specialists, counselors, podiatrists, acupuncturists, etc.

Please list all surgeries, hospitalizations and procedures.

Problem	**Surgery**	**Date**	**Doctor**	**Hospital**

Has your child ever had a head injury? Y N Age:

Has your child ever broken a bone? Y N Age:

Family History

Is your child adopted? Y N

Parents:

Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death: _____ Age (now or at death) _____

Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Siblings: None_____

Please list **siblings**, along with their **birth year**, any **medical problems** (and if deceased, their age at that time)

Grandparents:

Mother's Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Mother's Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Father's Mother: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Father's Father: birth year _____ Medical problems:_____
Alive? Y N Cause of death:_____ Age (now or at death) _____

Habits

How often does your family eat fast food? _____
Does anyone smoke in the child's home? _____
Are there guns, rifles or other firearms in the house?_____
Does your child have a television in their bedroom? _____
Is the child in school or preschool? Y N If so what grade? _____
Is your child disabled? Y N If yes, by what?_____

Life / Situational History

Birth Place:_____

Where did your child grow up:_____

What is your Religion: _____

Parents Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced
[ ]Widowed [ ] Separated

Do you live in: (*Please circle)* Apartment, Two-story home, One-story home
Please list *everyone* living in your household:

Name	**Relationship (if any)**	**Age**	**Occupation**

Signature: _____ Date: _____