CHRISTIAN
HEALTHCARE CENTERS

NAME:_____ DOB:_____

NEW PATIENT HISTORY (PEDIATRIC)

1. Does your child have (or ever had):
   - ☐ Nasal allergies
   - ☐ Eczema
   - ☐ Asthma, recurrent cough, or bronchitis
   - ☐ Pneumonia
   - ☐ Frequent ear infections
   - ☐ Problems with ears or hearing
   - ☐ Problems with eyes or vision
   - ☐ Speech delay or other development delay
   - ☐ Headaches
   - ☐ Constipation
   - ☐ Bladder/kidney infections
   - ☐ Heart problem or heart murmur
   - ☐ Anemia or bleeding problem
   - ☐ ADHD/attention problems
   - ☐ Anxiety
   - ☐ Depression
   - ☐ None of the above

2. Please list any other medical or mental health issues/problems that your child has now or has had in the past:

   _____

3. Please list any surgeries (including year):

   _____

4. Please list any hospitalizations (including reason and year):

   _____

5. Please list any medications (prescription or non-prescription) taken regularly:

   _____

6. Please list any medications allergies (include reaction):

   _____

7. Please list any other allergies (such as foods, pollens, dust, etc) or food intolerances:

   _____

   _____

8. Please list specialists or therapists your child has seen (include reason and year):

_____

_____

9. Was your child born early or were there any complications for your child during or after their delivery?

☐ NO ☐ YES, Details:_____

10. Please describe any reactions to vaccinations:

_____

11. What are your future plans for vaccinating this child?

_____

12. Please list everyone who lives in the home and their relationship to patient (include year of birth for children):

_____

_____

13. If biological/adoptive mother or father are not living together with child, what is the custody/parenting time status?

_____

14. What is your church home (if you have one)?

_____

15. How often do you attend church?

☐ Weekly ☐ Several times/month ☐ Monthly ☐ Occasionally ☐ Never

16. Are Christian values and habits (such as praying and Bible reading) important in your home?

☐ Very important ☐ Somewhat important ☐ Not important

17. Please describe any family medical history of AUTOIMMUNE DISEASES (such as hypothyroidism, celiac disease, Rheumatoid Arthritis, Type 1 Diabetes or lupus):

_____

_____

18. Please describe any family medical history of ASTHMA, ECZEMA, or significant ALLERGIES (including seasonal allergies):

_____

_____

_____

19. Please describe any family medical history of CHOLESTEROL> 240 or HEART ATTACK before age 45 years:

    _____

    _____

20. Please describe any family medical history of ANXIETY, DEPRESSION, BIPOLAR DISORDER or other mental health challenges:

    _____

    _____

21. Please describe any other medical conditions affecting your child's siblings, parents or grandparents:

    _____

    _____

    _____

22. Anything else you want us to know about your child or your family?

    _____

    _____

    _____

    _____