Horizon Family Medicine, PA
Five Locations With One Purpose . . . Your Health

INITIAL HISTORY (Newborn – 5 Yrs)

Child's Name (First, Middle, Last): ____ Date of Birth: _______________

Please fill out this form completely and print neatly to help us with your child's medical care.

1. What is the reason for today's visit? ____

2. List all current medications.

   Name | **Strength** | **How often?** | **How long have you been on it?**

   ____

   ____

   ❑ Check here if you are attaching a separate list.

3. Are there any medication allergies? ❑ Yes ❑ No If yes, please list medication and reaction: ___________________________

   ____

4. Who is the previous Care Provider? ____

Birth & Past Medical History

5. Birth weight: ____________ Length: ____________ Delivered: ❑ Vaginally ❑ by C-Section
6. Birth timing: ❑ Full-Term (37-40 weeks) ❑ Late (> 40 weeks) ❑ Premature (< 37 weeks)
7. Hospital and City of Birth: ____
8. List any problems during pregnancy or delivery: ____
9. List any medicine used during pregnancy: ____
10. List any problems during newborn period: ____
11. List previous Hospitalizations and/or Operations:

    Date | **Reason**

    ____

    ____

    ❑ Check here if you are attaching a separate list.

12. Check any past medical problems the child has had:

    ❑ Asthma ❑ Allergies ❑ Frequent ear infections ❑ Seizures ❑ Skin problems ❑ Food/formula intolerance

    ❑ Learning problems ❑ Heart problems/murmur

Feeding (only complete this section if child is less than 1 year old)

13. Liquids: ❑ Breast ❑Bottle Formula Type: ____

    Amount of juice per day: ________ Amount of milk/formula per day: ________

14. Solid foods: Fruit servings per day: ________ Vegetable servings per day: ________

Health Maintenance

15. Are your child's immunizations current? ❑ Yes ❑ No

    Please provide a copy of his/her immunization record to the front desk.

Child's Name (First, Middle, Last): ____ Date of Birth: _______________

Habits

16. Has your child had any unusual feeding or dietary problems? ❑ Yes ❑ No
17. Has your child had any sleep problems? ❑ Yes ❑ No
18. Do you live in a home built prior to 1972? ❑ Yes ❑ No
19. Has your child been to the dentist? ❑ Yes ❑ No
20. Do you use City Water? ❑ Yes ❑ No (If yes, what city? ______________________)

School History

21. Does your child attend daycare / preschool / school? ❑ Yes ❑ No (If yes, Name? ________________________)
22. Any concerns about school performance or relationships? ❑ Yes ❑ No
    If yes, please describe: ____
    ____

Family History

23. Please indicate if ANY family members have had the following (F=Father, M=Mother, B=Brother, S=Sister)

______ Alcoholism
______ Asthma
______ Autoimmune Disorder
______ Bleeding Disorder
______ Cancer
______ Depression / Attention Problems
______ Diabetes
______ Genetic Problem
______ Heart Disease
______ High Blood Pressure
______ Kidney Disease
______ Stroke
______ Substance Abuse
______ Thyroid Problem

Social History

24. Who lives at home? (List names and relationship to patient)
    ____
    ____
25. Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced (If divorced, when? __________________________)
26. What are the parent's occupations? Mother: ______________________________ Father: ______________________________
27. Who provides child care? ❑ Parents ❑ Others (If others, who? ____)

Safety

28. Does the child ALWAYS
    - Wear a bike helmet when riding? ❑ Yes ❑ No
    - Wear a helmet, pads and wrist guards when rollerblading/skateboarding? ❑ Yes ❑ No
    - Ride in a secure car seat or wear a seatbelt in vehicles? ❑ Yes ❑ No
    - Wear sunscreen when outdoors? ❑ Yes ❑ No
29. Is violence in the home a concern for you? ❑ Yes ❑ No
30. Is there a gun in your home? ❑ Yes ❑ No (If so, is it locked apart from the ammunition? ❑ Yes ❑ No)

____ ______________________________

Signature of Parent (or Legal Guardian) **Date**