

Windham Pediatrics
387-C Tuckie Road
North Windham, CT 06256

INITIAL HISTORY FORM

Today's Date: ____/____/____

Child's Name _____ DOB: ____/____/____ Sex: ____ (male) ____ Female

Address: _____ Home Phone: _____

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Primary Care Giver: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Household Members:

Name	Age	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pets in Household: ____ (no) ____ (yes), If yes, ____ (cats) ____ (dogs) ____ (other)

Does any member of the Household smoke cigarettes/cigars/pipes: ____ (yes) ____ (no)

Does your child attend daycare?: ____ (yes) ____ (no). Family water supply ____ (well water) ____ (city water)

BIRTH HISTORY

Pregnancy Problems: ____ (no) ____ (yes), if yes please explain; _____

How long was your labor _____ Delivery: ____ (vaginal) ____ (C-section): Birth Weight _____

Was baby born on time? ____ (yes) ____ (no); If no, how early was baby _____ Breast fed ____ (yes) ____ (no)

Newborn problems: _____

Do you have any concerns about baby's development: ____ (no) ____ (yes), if yes, please tell us your concerns; _____

PAST MEDICAL HISTORY

Allergies to foods; _____ Allergies to Medications; _____

Current Medications; _____

Major/Chronic Illnesses; _____

Previous Hospital admissions; _____

Previous surgeries/operations; _____

FAMILY HISTORY

- | | | | |
|---------------------------------|------------|-----------|--------------------|
| 1. Asthma | ____ (yes) | ____ (no) | if yes, who? _____ |
| 2. Diabetes | ____ (yes) | ____ (no) | if yes, who? _____ |
| 3. Allergy to Meds. | ____ (yes) | ____ (no) | if yes, who? _____ |
| 4. HIV | ____ (yes) | ____ (no) | if yes, who? _____ |
| 5. Heart Disease | ____ (yes) | ____ (no) | if yes, who? _____ |
| 6. High Blood Pressure | ____ (yes) | ____ (no) | if yes, who? _____ |
| 7. Seizures | ____ (yes) | ____ (no) | if yes, who? _____ |
| 8. Tuberculosis | ____ (yes) | ____ (no) | if yes, who? _____ |
| 9. Sickle cell disease or trait | ____ (yes) | ____ (no) | if yes, who? _____ |
| 10. Childhood Cancer | ____ (yes) | ____ (no) | if yes, who? _____ |
| 11. Cancer | ____ (yes) | ____ (no) | if yes, who? _____ |
| 12. Birth Defects | ____ (yes) | ____ (no) | if yes, who? _____ |
| 13. Other _____ | | | |

Form completed by _____ Relationship to child _____

Reviewed by _____ M.D.