New Patient Health History
Firefly Pediatrics

Child's legal name: _____Date of Birth: _____

Birth history:
Mother's pregnancy was (check one):
□ Healthy and uncomplicated
□ Complicated (list problems: _____)
□ Not sure or don't know (for example, if your child was adopted)

Mother's OB/GYN: _____ City/State: _____

Child was born: □ On time □ Early (How early? _____) □ Late □ Not sure

Child was born by: □ Vaginal delivery □ Cesarean section (Reason: _____) □ Not sure

Child was born at: □ ETCH □ Cumberland Medical Center □ Erlanger □ Other: _____

Birth weight (approximate is ok): _____ □ Not sure

Right after birth:
□ Baby was healthy and went home in a few days
□ Baby had some problems (list: _____)
□ Baby had to stay in the special care nursery / NICU a long time
□ Not sure

Medical history: Last check-up date: _____ Location: _____
Please check any of the following problems your child has (or has had):

□ Allergies
□ Asthma
□ ADHD
□ Bedwetting (> age 6)
□ Behavior problems
□ Birth defects
□ Blood problems
□ Bowel or liver problems
□ Cancer
□ Constipation
□ Cough (more than normal)
□ Depression
□ Developmental delay
□ Diabetes
□ Genetic disease
□ Growth problems
□ Headaches or migraines
□ Hearing problems
□ Heart defects
□ High blood pressure
□ Immune problems
□ Infections (more than normal)
□ Learning or school problems
□ Neurologic problems
□ Pain (more than normal)
□ Reflux or heartburn
□ Seizures
□ Scoliosis
□ Thyroid / gland disease
□ Urinary tract infections
□ Vision or eye problems
□ Weakness or fatigue
□ Weight problems
□ Wheezing/breathing problems
□ Other: _____
_____
_____
_____
□ Anything else that worries or concerns you

Please describe the items you checked (when they started, how often, how bothersome, etc.)

(Continued on reverse side)

Other medical history:

Have you had to take your child to the emergency room or walk-in clinic in the past year?

□ No □ Yes (For what and when? _____)

Has your child ever been admitted to the hospital overnight?

□ No □ Yes (For what and when? _____)

Previous traumatic injuries: □ None or _____

(Broken bones, concussions, etc.)

Child's previous surgeries: □ None or _____

(Ear tubes, tonsillectomy, appendectomy, etc.)

Child's current medications: □ None or _____

(Don't forget supplements, inhalers, creams, etc.)

Child's allergies: □ None or _____

Preferred Pharmacy: _____

Family history:

Please check anything that runs in your child's family (mother's or father's side)

- □ Asthma
- □ Allergies
- □ Behavioral problems
- □ Birth defects
- □ Cancer (type: _____)
- □ Diabetes (adult or juvenile)
- □ Genetic diseases
- □ Heart attacks (under age 55? Y N)
- □ Heart disease (besides heart attacks)
- □ High blood pressure
- □ High cholesterol
- □ Immune problems
- □ Learning problems
- □ Mental illness / Addiction
- □ Miscarriages or Stillbirths
- □ Seizures
- □ SIDS / crib death
- □ Other (list: _____)
- □ None
- □ Unknown

For things you checked, please list who has what (child's maternal uncle, paternal great grandma, etc.)

Social history:

Who lives at home with the child? _____

Pets at home: □ No □ Yes (kind: _____)

Smokers at home: □ No □ Yes Family's water supply: □ City water □ Well water

Child: □ goes to school/daycare at _____ □ is home schooled □ is too young for school

Child is in _____ grade Special educational needs? □ No □ Yes

(Describe: _____)

Please list anything else about your child or his environment that might be helpful for us to know (recent stresses in the family, special religious or faith needs, etc.)
