



**Patient History Form**

**Please complete the form prior to your appointment. Send through the Spruce App or bring to your first appointment.**

Child's Full Name:  
Child's Full Name:  
Child's Full Name:  
Child's Full Name:

Date of Birth:  
Date of Birth:  
Date of Birth:  
Date of Birth:

Date:

**Tell us about your family:**

**Home situation** (circle, or add in writing):

Single \_\_\_\_\_ Married (how long \_\_\_\_\_) Divorced (how long \_\_\_\_\_) Widowed (how long \_\_\_\_\_)

Domestic partnership \_\_\_\_\_ Children \_\_\_\_\_ Are they healthy? \_\_\_\_\_

**Employment:**

Status: full-time \_\_\_\_\_ part-time \_\_\_\_\_ retired \_\_\_\_\_ disabled \_\_\_\_\_ homemaker \_\_\_\_\_

**Occupation:**

type of work/jobs: \_\_\_\_\_

**Habits:**

Do you smoke? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_  
 If you have quit, how long ago? \_\_\_\_\_

Do you use other tobacco products? No \_\_\_\_\_ Yes \_\_\_\_\_ If so, which products? \_\_\_\_\_

Do you use alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how often do you drink? \_\_\_\_\_  
 If you have quit, how long ago? \_\_\_\_\_  
 Do family or friends worry about your alcohol intake? \_\_\_\_\_

Do you use illicit drugs? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please specify \_\_\_\_\_

**Nutrition Habits:**

1. How would you describe your child's eating habits?
2. Are you on a special diet (diabetic, low fat, vegetarian, etc.?)

**Exercise Habits:**

1. Does your child get physical activity on a regular basis? (3 or more times/week for 20-30 minutes or more)
2. What type of activity do they do?
3. If they do not get physical activity is it due to a particular reason (physical limitations, job, family life, etc.?)

**Psycho/Social:**

1. How do you feel your child does socially?
2. How would you describe your child's overall mood?
3. Is your family or has your family undergone any major issues/stresses in your life?
4. If yes, how does your child cope with these issues or stressors? How do you cope with these issues or stressors?

**Allergies or Adverse Drug Reactions:**

Please list drug and type of reaction

**Past Medical History:**

Please list other diseases from which your child currently suffers (heart, lung, etc.):

Please list other medical conditions from which your child has suffered in the past:

**Surgical History:**

Please list any surgeries (operations), reason for the surgery, and the date of the surgery:

**Medications:**

Prescription medications	Dose	How often taken

**Non-prescription /Supplements** (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

**Family History:**

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

**Does your child have Health Care Surrogate/Health Care Directives?** (If yes, please provide a copy at your first visit)

**Immunizations:** if YES, give approximate year given

Pneumococcal            No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis A             No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis B             No \_\_\_\_\_ Yes \_\_\_\_\_  
 Tetanus                 No \_\_\_\_\_ Yes \_\_\_\_\_  
 Shingles                No \_\_\_\_\_ Yes \_\_\_\_\_  
 HPV Vaccine            No \_\_\_\_\_ Yes \_\_\_\_\_

**Safety:**

Is your child in a car seat? No \_\_\_\_\_ Yes \_\_\_\_\_  
 Is your child in a booster seat? No \_\_\_\_\_ Yes \_\_\_\_\_  
 Do you use seatbelts?    No \_\_\_\_\_ Yes \_\_\_\_\_  
 Does your child wear a helmet when riding a bike or skates? No \_\_\_\_\_ Yes \_\_\_\_\_

**Transfusions:**

Has your child ever received a blood transfusion? No \_\_\_\_\_ Yes \_\_\_\_\_ When? \_\_\_\_\_

**Please mark any symptoms your child is currently experiencing or have experienced in the last month:**

**SYMPTOM REVIEW****Gastrointestinal**

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools

**Cardiovascular**

- chest pain
- history of irregular beat
- history of poor circulation

**Pulmonary/lungs**

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

**Muscle/joint/bone**

- swelling of ankles or legs  
pain, weakness or numbness in
- arms or hands
- back or hips
- legs or feet
- neck or shoulders

**Neurologic**

- history of stroke
- blackouts or loss of consciousness

**General**

- weight gain/loss of 10+ lbs during last 6 months
- poor sleep
- fever
- headache

**Eyes, ears, nose, throat**

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

**Genitourinary**

- frequent or painful urination
- blood in urine

**Skin**

- itching
- easy bruising
- change in moles

**Endocrine**

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

**Women only**

- Started menstruating
  - if yes, age \_\_\_\_\_
- abnormal Pap smear
- bleeding between periods

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**Anything else?**

- Are there any specific personal issues you would like to bring up at the time of your visit?

**PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT**