

Pediatric Patient Health History Form

Name: _____ DOB: _____ Birth city/country: _____

Birth Hospital: _____ Was the baby premature? _____ Medical problems at birth: _____

Mom's name at time of birth: _____ Your name: _____ Relationship to child: _____

Birth Family medical history (tell us which relative has the problem):

<input type="checkbox"/> Diabetes as a child/teen	<input type="checkbox"/> Seizures
<input type="checkbox"/> Depression/Anxiety/Bipolar/ADHD	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sickle Cell of trait
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Drug Abuse/smoking/alcohol abuse
<input type="checkbox"/> Learning problems	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Heart disease or sudden death
<input type="checkbox"/> Migraines	Other: _____

Child's Health:

Child's previous doctor's Office(s): _____

Previous surgeries (approximate dates and for what): _____

Overnight hospitalizations (when and for what): _____

History of chronic illnesses (i.e. sickle cell, hearing loss, asthma, ADHD): _____

Medications child takes/has taken in past: _____

Allergies to medicine, food, latex, beestings, etc: _____

History of lead poisoning or anemia (low iron)? _____

Does your child seem to be identifying with the gender they were assigned at birth? _____

If your child has suffered from an emotional trauma (like violence/family member death/jail/bad accidents/bullying/or abuse), please let the medical provider know.

Please name any concerns you may wish to share with your medical provider:

Child's Environment:

Who lives at home with the child? _____

Does anyone smoke that takes care of the child (inside or out)? _____

Is your child around anyone who owns a gun? _____

Is your child in daycare or school, and if so, what school and what grade? _____

Is your family part of a particular faith or religious community? Yes/No If so, please describe: _____

Our Mission

"To give honor to Jesus Christ by providing accessible, comprehensive health care in partnership with our patients and community leading to healthy, changed lives."

One of Crossroad's guiding principles is that we "promote the health of the whole person - body, mind, and spirit, acknowledging God as the ultimate source of all health." Is your faith important to you in relationship to your health?

Yes No Not sure

Would you be open to prayer for your family during your Crossroad appointment? _____

Please ask us if you would like a New Testament, or would like a list of churches in your community!