Niaz Medical Services. P.C.

NAME: _____ **DOB**: _____ **SEX**: _____

INITIAL HISTORY FORM

BIRTH HISTORY:
Did the mother have any medical problem while pregnant? _____
Birth weight: _____Birth length: _____
Was the delivery _____Normal (vaginal) _____Cesarean
Was the baby born at term or early? _____

PAST MEDICAL HISTORY:
Has the child has any medical problem? _____
_____
Has the child ever been hospitalized? _____
Is the child allergic to any medicines or drugs? _____
Is the child allergic to any food? _____
Has the child had any surgery, serious injuries or accidents? _____
_____
Who was your child's previous doctor? _____

SOCIAL INFORMATION:

Who does patient live with? _____
Are parents? ____ Married ____ Divorced ____ Separated ____ Partner
Do parents live together? ____ Yes ____ No
If parents are divorced/separated, is other parents involved? ____ Yes ____ No
What type of home do you live in? ____ Apartment ____ House
Are there any stairs? ____ Yes ____ No
Are there any pet in the home? ____ Yes ____ No If Yes, what type? _____
Any gun at home_____ Yes _____No If Yes, is it placed at the safe place? _____
Does anyone in the home smoke? _____
Is there any Home Care Agency involved with you child? ____ No ____ Yes
If yes, name of agency: _____
Contact Person: _____ Ph #: _____ Fax#: _____
Does your child attend any special program? ____ No ____Yes
If yes, name of program: _____
What grade is your child in? _____ Name of School: _____
School Ph #: _____
Guidance Counselor: _____ Ph#: (_____) _____