PEDIATRIC NEW PATIENT HISTORY

To facilitate our getting to know your child and provide them with comprehensive care, we would appreciate your cooperation in completing both sides of this form in regards to their health. Please complete by checking the appropriate box. If further explanation is necessary, please add comments where appropriate. When you meet with the clinician you may be asked for some detail regarding your responses to clarify issues. Thank you for your time and effort.

GENERAL INFORMATION:

NAME:_____ DATE OF BIRTH:_____ MALE / FEMALE DATE:_____

HOW DID YOU HEAR OF OUR PRACTICE?_____

OTHER MEMBERS OF YOUR HOUSEHOLD:

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		

REASON FOR YOUR VISIT TODAY:_____

ALLERGIES TO MEDICATIONS, FOOD, INSECTS, POLLENS, ETC: Please include child's reaction:

_____

_____

MEDICATIONS YOUR CHILD TAKES CURRENTLY: Please include over-the-counter and vitamins

NAME	DOSE (MG)	# TIMES PER DAY	NAME	DOSE(MG)	# TIMES PER DAY

PAST MEDICAL HISTORY: Please circle the appropriate answer and provide explanation when necessary

BIRTH WEIGHT: _____ BORN ON TIME? YES / NO IF NOT, HOW EARLY/LATE?_____

DELIVERY: VAGINAL FORCEPS C-SECTION

COMPLICATIONS WITH THE PREGNANCY OR DELIVERY?_____

OXYGEN NEEDED AT BIRTH? YES / NO

HOSPITALIZED OVERNIGHT OR SURGERY? YES / NO_____

CHRONIC ILLNESSES? (i.e. asthma, eczema, ear infections, diabetes, heart problems, urinary tract infections) YES / NO

_____

_____

SERIOUS ACCIDENTS OR INJURIES? YES / NO_____

IMMUNIZATIONS UP TO DATE? YES / NO Please provide records of all immunizations child has received

FAMILY HISTORY:

FATHER is living at _____ years old. Health Problems:_____

Deceased at _____years old. Cause of Death:_____

Health problems on father's side of family:_____

MOTHER is living at _____ years old. Health Problems:_____

Deceased at _____years old. Cause of Death:_____

Health problems on mother's side of family:_____

BROTHERS: How many?_____ Any medical problems:_____

SISTERS: How many?_____Any medical problems:_____

SONS: How many?_____Any medical problems:_____

DAUGHTERS: How many?_____Any medical problems:_____

SOCIAL HISTORY

PARENTS MARITAL STATUS:_____

IF SEPARATED, HOW IS CUSTODY/TIME SPLIT? _____

WHO HAS MEDICAL DECISION MAKING AUTHORITY?_____

MOTHER'S OCCUPATION:_____ FATHER'S OCCUPATION:_____

DOES ANYONE SMOKE AT HOME? YES / NO

PETS? YES / NO _____

DOES HOME HAVE SMOKE DETECTORS? YES / NO

DOES CHILD RIDE IN A CAR SEAT (IF <80LBS)? YES / NO

DOES CHILD WEAR A BIKE HELMET? YES / NO

HOW MANY HOURS OF TV WATCHED BY CHILD PER DAY?_____

OTHER CONCERNS OR QUESTIONS?

DO YOU HAVE ANY GUNS AT HOME? YES / NO

ANY CONCERNS ABOUT HEARING, VISION, SPEECH? YES / NO

ANY EMOTIONAL OR PHYSICAL VIOLENCE AT HOME? YES / NO

ANY CONCERNS ABOUT SCHOOL PERFORMANCE OR BEHAVIOR? YES / NO

Thank you very much for your time and effort in completing your child's medical record. Please sign and date below.

SIGNATURE:_____ DATE COMPLETED:_____

RELATION TO PATIENT:_____

PHYSICIAN'S SIGNATURE:_____ DATE REVIEWED:_____

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