Pediatric New Patient History Form

Date: _____

Patient Name:_____Age:_____Date of Birth:____/____/____

Reason for today's visit?_____

Who Lives In Home With Child:

Names:	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History – did the child's mother have any of the following during pregnancy:

High Blood Pressure	Y – N_____
Bleeding	Y – N _____
Diabetes	Y – N _____
Preterm Labor	Y – N _____
Infections	Y – N _____
Smoking	Y – N _____
Alcohol or Drug Use	Y – N _____
Sexually Transmitted Diseases	Y – N_____

Other:_____

Other:_____

Did the child's mother have any complications during or after labor? Y – N

Did the child's mother have a caesarean section? Y – N

Did the child have any problems requiring extended treatment in nursery? Y – N

At how many weeks was the child delivered?_____

What was the baby's birth weight?_____

Medical History:

Date	Hospitalizations (& reason)	Surgeries (Date / Reason)

Medications (including over the counter):

List Any Allergies:

Do you or the people your child stays with have the following?

Pets: Y – N_____

Weapons: Y – N _____

Swimming Pool Y – N _____

Smokers: Y – N _____

Does the house(s) where your child stays have lead paint? Y – N

Is/Are the house(s) more than 30 years old? Y – N

At what age did your child first walk? _____

What grade is your child now in?_____

Does child do well in school?_____

If no, please explain:_____

_____

_____

_____

talk?_____

(Continued on back)

Please check any that apply to your child or a family member:

	Child	Family Members	Comments
Allergies			
Anemia			
Anxiety			
Asthma			
Attention Deficit Disorders			
Bleeding or Bruising Disorder			
Cancer			
Cystic Fibrosis			
Deafness			
Depression			
Diabetes			
Drug Abuse			
Ear Infections			
Genetic Diseases			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Learning Disabilities			
Liver Disease			
Lung Disease			
Migraines			
Mental Retardation			
Muscle Weakness Disease			
Seizures/Convulsions			
Skin Disorders			
Stomach Problems			
Thyroid/Other Endocrine Problems			
Tuberculosis			
Visual Problems			
Other			

If mother and father are not living together or if the child does not live with parents, what is the child's custody status?

_____

If one or both parents are not living in the home, how often does child see the parent(s) not in the home?_____

_____

IN CASE OF EMERGENCY, NOTIFY:

Name:_____Home Phone_____Work Phone_____
Relationship to patient_____

Name:_____Home Phone_____Work Phone_____
Relationship to patient_____

Signature of Parent/Legal Guardian of Minor_____Date_____
Relationship to Patient/Minor_____