

## Pediatric New Patient Medical History Form

Last Name:	First Name:	Preferred Name:
Today's Date:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
School:	Grade:	
Mother's Name:	Father's Name:	
Mother's Occupation:	Father's Occupation:	
Child Lives With: <input type="checkbox"/> Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:		

If child does not live with parents how often does he/she get to see parents:

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Name of any specialist your child sees, the reason and last seen date:

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### Household

Please list all those living in the child's home (parents, siblings, grandparents, etc...)

Name	Relationship to Child	Birth Date
Any Pets living in house with child?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, how many and what kind?		
Any guns in house?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do parents smoke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any household member use alcohol or drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO



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**Birth History**

Birth Weight: \_\_\_\_\_ lb \_\_\_\_\_ oz

Was the delivery:  Vaginal     Cesarean

Was the baby born at (Circle one):    Term    Early    Late

If cesarean why? \_\_\_\_\_

If early how many weeks gestation: \_\_\_\_\_

Did your baby have any problems immediately after birth:  
 YES     NO  
 If yes explain: \_\_\_\_\_

Where was baby born? \_\_\_\_\_

Did baby go home with mom:  YES     NO

Was initial feeding after birth:  Breast     Bottle

Did baby go home with mom:  YES     NO

Explain: \_\_\_\_\_

Did mother have any illnesses during or problems with pregnancy:  YES     NO

If yes, explain: \_\_\_\_\_

During pregnancy did mother take any of the following?

Smoke:                     YES     NO    If yes how much: \_\_\_\_\_

Drink Alcohol:             YES     NO    If yes, what; how often; how many: \_\_\_\_\_

Drugs/Medications:       YES     NO    If yes what and how often: \_\_\_\_\_

Feeding And Nutrition:	YES	NO
Is your child's appetite good?		
Did your child suffer from colic in first three months?		
Does your child take Vitamins or herbal supplements?		
Is your child a picky eater?		
Developmental:	YES	NO
Are you concerned about your child's physical development?		
Are you concerned about your child's emotional development?		
Are you concerned about your child's attention span?		
Does your child have trouble sleeping?		
Does your child get along with other children?		
Did your child say any words by 1 1/2 years old?		





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### Food Insecurities

In the last 12 months, I worried whether my food would run out before I got money to buy more.

- Often true                     
  Sometimes true                     
  Never true                     
  Declines/Unable to Answer

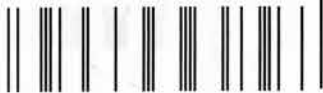
In the last 12 months, the food I bought just didn't last and I didn't have money to buy more.

- Often true                     
  Sometimes true                     
  Never true                     
  Declines/Unable to Answer

### Allergies to Medications/Environmental

Please list any medications/foods/insect bites that has had any type of reaction to or is allergic to:

Medication/Food/Insect Bites Allergy	Reaction



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**Family Medical History:**

Condition	Mother	Father	Sibling	Grandparent
Alcohol Abuse				
Anemia				
Asthma/Reactive Airway Disease				
Autoimmune Disorder				
Bed Wetting (after age 10)				
Bleeding Disorder				
Congenital Deafness				
Diabetes (Before age 50)				
Drug Abuse				
Epilepsy or Convulsions				
Heart Disease (Before age 50)				
High Blood Pressure (Before age 50)				
High Cholesterol				
Immune Disorder				
Immune Problems (HIV/AIDS)				
Kidney Disease				
Liver Disease				
Lupus				
Mental Illness				
Mental Retardation				
Nasal Allergies				
Tuberculosis				
Other:				

**Medication History**

**Please list any medications your child takes daily:**

Medication	Strength	Times a Day	Reason



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**Child's Past Medical History:**

Condition	Yes	No	Explanation
Abdominal Pain			
Anemia, Bleeding Problems, blood transfusion			
Anxiety/Depression/ADHD/other			
Asthma, Bronchitis, Bronchiolitis, pneumonia			
Bed Wetting (after age 5)			
Bladder/Kidney Problems			
Bowel Problems/ Constipation			
Chicken Pox			
Chronic / Recurrent Skin Problems (acne, eczema, etc.)			
Concussion/ Head injury			
Developmental delay			
Diabetes			
Ear Problems			
Eating Disorder			
Eye Problems			
Headaches			
Heart Problems			
Mental Illness			
Mental Retardation			
Nasal Allergies			
Neurological problems (Convulsions, seizures, etc.)			
Recurrent infections			
Resource class/special ed			
Thyroid			
For Girls: Menstrual Period Began?			
Use of drugs / alcohol			
Other:			

**Surgeries**

**Please indicate any surgeries/ hospitalizations your child has had:**

Type of surgery	Date of Surgery

\_\_\_\_\_  
 Patient or Parent/Legal Guardian (if patient is considered an incapacitated minor) (signature) Date

\_\_\_\_\_  
 Witness Signature Print Name Date Time

