MRN (office use only):________

New Patient History Form (Pediatric)

Please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and your child plus target any concerns/issues you may have.

Child's Name: ________________________________ Date of Birth: ____________ Date: ______________

Child's Place of Birth: ________________________________ City: ________________________________

Mother's Name: ____________________________Date of Birth: __________Profession:_________________

Employer: ______________________________ Work #:________________Home #:________________

Father's Name: ____________________________Date of Birth: __________Profession:_________________

Employer: ______________________________ Work #:________________Home #:________________

Parent's Status: Married Single Separate Divorced Living Together

Who does the child live with? ____

Name of guardian (if applicable):____________________________ Relationship to child: __________________

Name of siblings: ____

List other members in the household: ____

Was your child adopted? **Y** **N** If yes, at what age?_________ From what country/city_________________________

Religious preference (voluntary): ____

Medical History:
Please list any medical conditions your child has been treated for in the past. Examples: heart problems, bone or joint problems (bracing/casting), jaundice, allergies, chicken pox, eczema, asthma, strep throat, recurring ear infections, ect.

____

____

Surgical History / Hospitalization:
Please list any operations or hospitalizations your child has had. Please include the dates.

____

____

Medications:
Please list medications your child is currently taking, this includes over the counter medications and herbal supplements.

____

____

Allergies:
Please list any medications and foods your child is allergic to and what happens when he or she takes that medication or food.

Please check box if your child is allergic to latex: □ **Please check box if your child has no known allergies:** □

____

____

Family History:
Please list the age (or age at death) and any illnesses for the following family members. This includes diabetes, heart disease, kidney problems, cancer, high blood pressure, depression, arthritis, and allergies.

Child's Mother:	**Child's Father:**
Mom's Mother:	**Mom's Father:**
Dad's Mother:	**Dad's Father:**
Child's Siblings:	

MRN (office use only):________

Child's Name: ____

IMMUNIZATIONS: PLEASE PROVIDE US WITH AN UPDATED LIST OF YOUR CHILD'S IMMUNIZATIONS

If your child is under ____ years of age, please complete the following section.

Mom's Pregnancy History

Number of pregnancies before this child (including miscarriages)___________________________

How long was this pregnancy (# of weeks)___________________________

When was prenatal care started for this child (months pregnant): ___________________________

List any illnesses you experienced during this pregnancy (high blood pressure, diabetes, thyroid problems)

____

List any medications you took during the pregnancy: ___________________________

Did you smoke during pregnancy? **Y N** Any alcohol consumption? **Y N** Any drug use? **Y N**

Patient's Birth History:

Length of labor (hours) ________ Was labor induced? Y N If yes, why? ___________________________

Delivery (circle all that apply): Breech presentation C-section VBAC Breathing problems Vacuum Forceps

Nursery: (circle all that apply): Neonatal ICU admission Antibiotics Lights for jaundice Blood transfusion Oxygen needed

Birth weight: ________ Birth length: ________Discharge weight: ________ Apgar score: ____ Time spent in hospital: ________

Newborn screen performed in hospital? **Y N** Hepatitis B vaccine given in nursery? **Y N**

Please describe any other problems: ___________________________

____

Nutrition History:

Breast fed? **Y N** Duration:___________ Formula fed? **Y N** Type of formula:___________________ Duration:________

At what age were solid foods introduced? _______________ Does your child use a pacifier? **Y N**

Is your child taking vitamins? **Y N** Is your child using a fluoride supplement? **Y N**

Any feeding issues? (circle all that apply) Vomiting or reflux Colic Diarrhea

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If your child is over ___ years of age, please complete the following section.

Growth and Development:

What age did your child perform the following?

Sit alone: _____ Walk alone: _____ Start saying 1-2 words: _____ Feed self: _____

Potty train (day): _____ Potty train (night): _____ Dress self: _____

Talk in 2-3 word sentences: _____ What grade is your child in? _______

Any problems in school? ___________________________

____

Any behavioral problems? ___________________________

____

For Girls Only: Have you started your period? Y N If yes, at what age? _________

Thank you for taking time to fill out the forms. Please sign and date:

Parent/Guardian: ___________________________ Date: ___________________________

Print Name: ___________________________ Relationship to patient: ___________________________

Physician: ___________________________ Date: ___________________________