Pediatrics P.C. New Patient History

Name_____ DOB_____ M/F_____

Form completed by_____ Relationship to patient?_____

Date of Completion_____

Birth History

Birth Weight_____

Was the delivery vaginal or by C-section?_____
If C-section why?_____

Did the mother have any problems or illness during her pregnancy? ☐No ☐Yes _____

During pregnancy, did mother:
Smoke ☐Yes ☐No Drink Alcohol ☐Yes ☐No
Use presription medications or other drugs ☐Yes ☐No
What_____ When_____

Was baby born at term, early or late?_____

Did your baby have any problems right after birth?
☐No ☐Yes Explain_____

Was initial feeding ☐Bottle ☐Breast (for how long?)_____

Was your baby discharged from the hospital with the mother?
☐Yes ☐No Explain_____

General

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain_____
Does your child have any serious illness or medical condition?	☐ Yes	☐ No	Explain_____
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain_____
Has your child had any surgery?	☐ Yes	☐ No	Explain_____
Has your child been hospitalized overnight?	☐ Yes	☐ No	Explain_____
Is your child allergic to any medications?	☐ Yes	☐ No	Explain_____
Is your child currently taking any medications?	☐ Yes	☐ No	Explain_____

Past History

Does your child have, or has he/she ever had:

Chicken Pox	☐ Yes	☐ No	Bed-wetting (after 5 years old)	☐ Yes	☐ No
Frequent ear infections	☐ Yes	☐ No	Started menstrual periods?	☐ Yes	☐ No
Problems with ears or hearing	☐ Yes	☐ No	Problems with periods?	☐ Yes	☐ No
Nasal allergies	☐ Yes	☐ No	Chronic or recurrent skin problems	☐ Yes	☐ No
Problems with eyes or vision	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No
Asthma, pneumonia, bronchiolitis	☐ Yes	☐ No	Seizures or neurologic problems	☐ Yes	☐ No
Heart problem or murmur	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Anemia or bleeding problem	☐ Yes	☐ No	Thyroid or endocrine problems	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Use of alcohol or drugs	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No	Any other significant problem?		
Constipation requiring doctor visit	☐ Yes	☐ No	Explain_____		
Bladder or kidney infection	☐ Yes	☐ No			

*If you need more space to answer any of the questions, please use the back side of this form.

REVIEWED BY: _____ DATE:_____