

Pediatrics P.C. New Patient History

Name _____ DOB _____ M/F _____

Form completed by _____ Relationship to patient? _____

Date of Completion _____

Birth History

Birth Weight _____

Was baby born at term, early or late? _____

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

Did your baby have any problems right after birth?
 No Yes Explain _____

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

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

During pregnancy, did mother:
Smoke Yes No Drink Alcohol Yes No
Use prescription medications or other drugs Yes No
What _____ When _____

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
- Frequent ear infections Yes No
- Problems with ears or hearing Yes No
- Nasal allergies Yes No
- Problems with eyes or vision Yes No
- Asthma, pneumonia, bronchiolitis Yes No
- Heart problem or murmur Yes No
- Anemia or bleeding problem Yes No
- Blood transfusion Yes No
- Frequent abdominal pain Yes No
- Constipation requiring doctor visit Yes No
- Bladder or kidney infection Yes No

- Bed-wetting (after 5 years old) Yes No
- Started menstrual periods? Yes No
- Problems with periods? Yes No
- Chronic or recurrent skin problems Yes No
- Frequent headaches Yes No
- Seizures or neurologic problems Yes No
- Diabetes Yes No
- Thyroid or endocrine problems Yes No
- Use of alcohol or drugs Yes No
- Any other significant problem?
Explain _____

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

REVIEWED BY: _____ DATE: _____