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PEDIATRIC NEW PATIENT FORM

(*1 to 18 years*)

Patient's Name_____ Date of 1st Appointment _____

Age_____Date of Birth _____Gender: Male ❒ Female ❒

Mother's Name (first/last) _____

Father's Name (first/last) _____

Parents Relationship Status: Single ❒ Married ❒ Divorced ❒ Widowed ❒

Living Situation: Alone ❒ Friend(s) ❒ Partner ❒ Spouse ❒ Parents ❒ Children ❒

Who can we thank for referring you to our office/services? _____

HOW CAN WE SUPPORT YOU AND THE HEALTH OF YOUR CHILD:

_____

_____

_____

_____

_____

KNOWN ALLERGIES OR SENSITIVITIES:

Drug *(penicillin, etc.)*_____

Food *(gluten, casein, etc.)* _____

Environmental *(smoke, pollen, animal, etc.)* _____

Chemical *(perfumes, etc.)*_____

PRENATAL HISTORY:

Mother's age at child's birth_____ What number pregnancy was this birth_____

Number of miscarriages/abortions_____ Number of live births _____

Unplanned pregnancy ❒ In Vitro ❒ Artificial Insemination ❒ Amniocentesis ❒

Number of ultrasounds _____ Illness during pregnancy _____

Medications during pregnancy _____

Bleeding ❒ Nausea ❒ Illnesses ❒ Hypertension ❒ Swelling ❒ Diabetes ❒

Thyroid Issues ❒ Physical or Emotional Issues ❒ Cigarettes ❒ Alcohol ❒ Drugs ❒

Other _____

BIRTH HISTORY:

Term: Full ❒ Premature ❒ Late ❒ Birth Weight _____ Length _____
APGARs: 1 min. _____ 5 min. _____ Length of Labor _____
Home Birth ❒ Birth Center ❒ Hospital ❒ Complications, if any: _____

_____

_____

Pitocin ❒ Epidural or Spinal Anesthesia ❒ C-Section ❒ Forceps ❒ Episiotomy ❒
Vacuum Extraction ❒ Cord Wrapped Around Neck ❒ Merconium Staining ❒
Birth Defects ❒ Birth Injuries ❒ Blue Baby ❒ Cerebral Palsy ❒ Seizures ❒
Jaundice ❒ Colic ❒ Fever ❒ Rashes ❒ Unusual Cry ❒ Head Uneven ❒
Breast Fed Immediately ❒ Difficulty Latching ❒ Concerns? _____

_____

CHILD'S DIET HISTORY:

Breast fed ❒ How long? _____ How many hours between feedings _____
Formula ❒ Cow Dairy ❒ Goat ❒ Soy ❒ Other ❒ _____
Ounces per feeding _____ Difficulties? Explain: _____

_____

_____

Age were solids introduced _____ List First Foods? _____
Any Food Intolerances _____

CHILD'S CURRENT DIET: *(Describe Mother's diet if child is still nursing)*

Breakfast _____
Lunch _____
Dinner _____
Snacks_____
Fluids _____
Cravings/Intolerances _____

DEVELOPMENT:

Sleep Patterns:_____
AGE BEGAN: Sleeping Through Night _____ Sit Up _____ Belly Crawl _____
Creep on Hands/knees_____ Cruise _____ Walking _____ Talking _____
Used Swing ❒ Used Walker ❒ Concerns? _____

_____

HEALTH ISSUES/SYMPTOMS: *Please note if Current (C) or Past (P)*

❒ Hives
❒ Acne
❒ Skin Rash
❒ Eczema
❒ Easy Bruising
❒ Wheezing
❒ Coughing
❒ Asthma
❒ Frequent Colds

❒ Headaches
❒ High Fevers
❒ Hearing Loss
❒ Dizzy Spells
❒ Ear Infections
❒ Sore Throats
❒ Nose Bleeds
❒ Anemia
❒ Jaundice

❒ Cries Easily
❒ Stomach Aches
❒ Constipation
❒ Diarrhea
❒ Gas
❒ No Appetite
❒ Colic
❒ Motion Sickness
❒ Vomiting

❒ Nightmares
❒ Sleep Problems
❒ Unusual Fears
❒ Excessive Fatigue
❒ Light Sensitivity
❒ Irritableness
❒ Noise Sensitivity
❒ Heart Murmur
❒ Nervous

❒ Rigidly Arches Backwards
❒ Too Tight or Rigid Muscle Tone
❒ Helmet Used for Uneven Head
❒ Too Loose or Floppy Muscle Tone
❒ Torticollis (Head and Neck Side-bent)
❒ Difficulty Wearing Certain Clothing

FAMILY HISTORY:

Mother's Health _____

_____

Father's Health_____

_____

Sibling's Health _____

_____

_____

_____

Please list any major diseases/illnesses that run in family genetics with any grandparents, aunts, or uncles, i.e.: diabetes, cancer, heart disease, addictions, mental illness, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

ACCIDENTS/INJURIES: *(short description)*

MORE than 5 years ago _____

LESS than 5 years ago _____

HOSPITALIZATIONS OR SURGERIES: *(short description)*

Date *Hospital* *Diagnosis/Surgery* *Doctor*

_____

_____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING TESTS:

Electroencephalogram *Date*_____ *Where* _____

Results _____

Psychological Evaluation *Date* _____ *Where* _____

Results _____

Hearing Evaluation *Date*_____ *Where* _____

Results _____

Speech/Language *Date* _____ *Where* _____

Results _____

IMMUNIZATIONS:

Measles ❒ Mumps ❒ Polio ❒ DPT ❒ Influenza ❒ Rotoviras ❒ MMR ❒

Tetanus ❒ HIB ❒ Hepatitis A ❒ Hepatitis B ❒ Pneumococcal ❒

List others: _____

Adverse Reactions? *(Describe severity, length of time and age of reaction)* _____

_____

_____

_____

CURRENT MEDICATIONS: *Please note if Current (C) or Past (P)*

Medication Name	What's it for?	For how long?	Strength	Dose	Frequency

Name of Doctor's Office/Hospital/Clinic where your infant's health records are kept:

_____

CURRENT DIETARY SUPPLEMENTS, HOMEOPATHICS & HERBS: *(use back of paper if needed)*

Agent Name Brand/Product Name Potency (mg or IU, etc.) Dose Frequency

_____

_____

_____

_____

_____

MOTORSKILLS

Clumsiness ❒ Difficulty drawing a straight line, circle, square or complex figure ❒
(Age appropriate)

SCHOOL

Poor Grades ❒ Homework Difficult ❒ Poor Concentration ❒ Short Attention Span ❒

Does not get along w/classmates ❒ Makes Friends Easily ❒

School your child attends: _____ Grade Level_____

Strengths:

Math ❒ English ❒ Science ❒ History ❒ Reading ❒ Writing ❒ Drama ❒

Art ❒ Foreign Language ❒ PE ❒ Other ❒ _____

Weaknesses:

Math ❒ English ❒ Science ❒ History ❒ Reading ❒ Writing ❒ Drama ❒

Art ❒ Foreign Language ❒ PE ❒ Other ❒ _____

EXPOSURE/HABITS:

Smoker in household ❒ Sucks finger/thumb/lip/pacifier ❒ Nail Biting ❒

TV; hrs per day _____ **Computer**; hrs per day _____ **Video Games**; hrs per day_____

Playing w/Friends; hrs per day_____

Possible lead exposure (old home/plumbing/peeling paint/freeway) ❒

Other possible toxic exposures: _____

SOCIAL HISTORY:

Irritable ❒ Shy ❒ Aggressive ❒ Pets ❒ List kind/quantity: _____

_____

Father's Profession:_____Mother's Profession: _____

Either parent have a history of drug use?_____ Drug(s) _____

Current condition? _____

_____

_____