New Patient Information Form

South County PEDIATRICS
Washington University Clinical Associates

Child's Name: _____Date of Birth:_____ Age: _____

Child's Previous Doctor:_____ Medical Records Requested? Yes_____ No_____

Mother's Name_____ Age:_____ Height:_____ Occupation:_____

Father's Name_____ Age:_____ Height:_____ Occupation:_____

PREFERRED PHONE NUMBER:_____

How did you hear of our office?_____

Name of Hospital and city your child was born in:_____

Is this child by: _____ Birth _____Adoption _____ Step-child _____Other:_____

Birth Weight:_____ Was your baby premature? Y / N

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor or the baby's newborn period? Y / N

If YES to any of the above questions, please explain: _____

Growth and Development:

Have you or your prior pediatrician ever had any concerns about your child's growth and development (speech/language/social skills/motor skills, etc.)? Y / N

If yes, please explain:_____

Girls only: Age at first period: _____

Past Medical History:

Has your child:

Had pneumonia?	Y / N	Had hepatitis?	Y / N
Had a urinary tract infection (UTI)?	Y / N	Had any serious medical illness?	Y / N
Had a history of asthma or wheezing?	Y / N	Had broken bones/frequent or severe sprains?	Y / N
Ever used an inhaler or nebulizer?	Y / N	Had any mental or behavioral problems?	Y / N
Had surgery?	Y / N	Had a positive tuberculosis skin test?	Y / N
Been hospitalized overnight?	Y / N		

If yes to any of the above, please explain: _____

Immunizations: *Please bring your child's immunization records to the appointment.*

Have you ever refused vaccines for your child? Y / N

(TURN OVER TO BACK)

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Medications and Allergies:

Please list current medications, vitamins, and supplements, even those used intermittently:_____

_____

Please list allergies or reactions to medications, vaccines or foods Allergy Reaction

_____ _____

_____ _____

Family Health Information: Please circle Y or N, and write that person's ***relationship to your child*** (maternal grandfather, for example)

Disease		Relationship	**Disease**		Relationship
Alcohol abuse	Y / N		High blood pressure	Y / N	
Asthma	Y / N		Kidney disease	Y / N	
Cancer	Y / N		Learning problems	Y / N	
High cholesterol	Y / N		Mental illness, suicide, trouble with nerves	Y / N	
Adult onset diabetes	Y / N		Seizures	Y / N	
Childhood onset diabetes	Y / N		Stroke	Y / N	
Drug abuse	Y / N		Sudden unexplained death	Y / N	
Heart attack or heart disease	Y / N		Thyroid disease	Y / N	
Deafness	Y / N		Other disease	Y / N	

Social History: Please list patient's family and household members:

Name Age Relationship Name Age Relationship

_____

_____

_____

Are your child's parents _____ Married _____ Unmarried _____ Separated _____Divorced

Child-care situation: _____ Parents _____ Other: _____

Concerns about your child: ___Alcohol use ___Tobacco/nicotine use __Sexual activity ___ Aggressive behavior

Is violence at home a concern? ___ Yes ___ No Do you have pets at home? ___ Yes ___ No

If yes, what? _____

Are there guns in the home? ___ Yes ___ No Do any family members smoke? ___ Yes ___ No

If yes, are they locked up? _____ If yes, who? _____ Inside car/home? ____