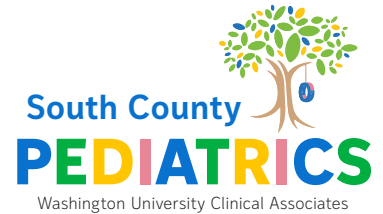


New Patient Information Form



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

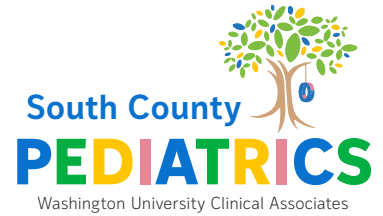
If yes to any of the above, please explain: _____

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)

New Patient Information Form



Child's Name: _____ Date of Birth: _____

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? _____