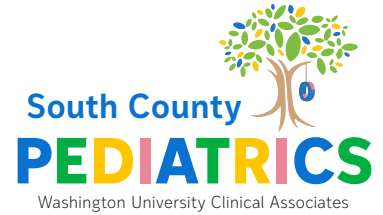


**New Patient Information Form**



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Child's Previous Doctor: \_\_\_\_\_ Medical Records Requested? Yes \_\_\_\_\_ No \_\_\_\_\_  
Mother's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Father's Name \_\_\_\_\_ DOB: \_\_\_\_\_ 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 \_\_\_\_\_ Stepchild \_\_\_\_\_ 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: \_\_\_\_\_

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**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

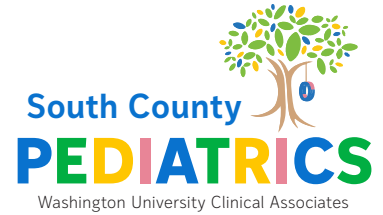
If yes to any of the above, please explain: \_\_\_\_\_

**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? \_\_\_\_\_