New Patient Information

Today's date ____________________ Allergies ____________________

Child's Name ____________________ Age ______ Date of Birth ____________________

BIRTH History: Where was your child born? __________ (City) ______ (State) ____________________ (Hospital/Facility) Circle One: C-Section Vaginal delivery

Birth Weight ________ Pounds-ounces Circle one: Full Term Pre-Term Any Difficulty at Birth? NO YES (If Yes, Please

Explain) ____

Has your child ever been in the hospital overnight or longer **OR** Had any Surgery in the Past? NO YES (If Yes, Please

Explain) ____

Is your child on any prescription medications or been on any long-term (more than 6 months) in the past? NO YES (If Yes, Please list them). Please include the dose and times daily taken for any current medications, and list any previous medications.

____________________ ____________________ ____________________

Has your Child Had **ANY** of the following diseases in the past: (Circle **ALL** that apply)
Ear Infections, Meningitis, Pneumonia, Bronchitis, Asthma, Allergies, Chronic Pain, Anemia, Sickle Cell Disease **or** Trait, Diabetes, **any** Cancer, Eye/Vision Disorders (including glasses), Heart Problems, Joint Problems, High Blood Pressure, Chronic Abdominal Problems, Headaches, Chronic Pain, Mental Disorders, Attention Deficit Disorders, Learning Problems/Delayed Development, or **ANYTHING NOT LISTED** ____

Who was your child's last doctor? Name ____________________ City,State ____________________

Do you think your child's immunizations are up to date? Yes No
Does you child have any **medication allergies** (including **latex**) that you know of? Yes No Please List ____________________

Family History: Circle **ANY** diseases that run in the family including the child's parents, brothers/sisters, uncles/aunts, cousins and grand parents: (Circle **ALL** that apply) Asthma, Allergies, **Childhood** Diabetes, Cystic Fibrosis, Arthritis, Migraines, HIV/AIDS, Tuberculosis, Cancer, Leukemia, Mental Health Disorders, Problems with Anesthesia, **Adulthood** Diabetes, High Blood Pressure, or **ANYTHING NOT LISTED** ____

Social History: Mother's Name ____________________ Age ______ Occupation ____________________

Father's Name ____________________ Age ______ Occupation ____________________
Parents' Marital Status (**circle**): Married Separated Divorced Single

List names of any Brother/Sisters and ages ________ ____________________

Any difficulty amongst household members that you feel needs to be discussed at this time or during a future visit? NO YES
If yes, Please explain. ____

Are there any pets in the home? Yes No Please list type(s) of animal(s) ____________________

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Is there anything you wish to discuss **privately** with the doctor ? Yes No

Can you think of anything else that would be helpful for me to know about your child (use also if you need more room for questions above)? ____

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CIP-34691A-09/12-500