New Patient Information and Medical History

Child's Full Name_____ **Date of Birth**_____

Address_____ **City**_____ **State**_____
Zip Code_____ **Phone Number**_____**Alternate Phone Number**_____

Previous Doctor _____

How did you hear about us? _____

Mother's Name_____ **Father's Name**_____
Mother's Occupation_____ **Father's Occupation**_____
Does mother live with Child? [ ] Yes [ ] No **Does father live with child?** [ ] Yes [ ] No

Legal Guardian Name_____ **Siblings Names/Birthdates:** _____
Is the child adopted? [ ] Yes [ ] No _____
Is the child in foster care? [ ] Yes [ ] No _____
_____

Mother's age at birth_____ **Type of delivery** [ ] Vaginal [ ] C-section

Weight at birth _____

Was baby born early? [ ] Yes [ ] No **Number of day's baby stayed in the hospital after birth**_____

Check if mother had any of the following during pregnancy or delivery:
[ ] Infection [ ] Diabetes [ ] Drug/Alcohol use [ ] Cigarette use [ ] Early Labor [ ] Other complications

Medical History	Yes	No	Explain (include dates if known)
Does your child have any chronic conditions or diseases?			
Hospitalizations?			
Surgeries?			
Emergency room visits?			
Food Allergies?			
Medication allergies?			
Immunization reactions?			

Check if your child has *ever* had any of the following:

[ ] Chickenpox
[ ] Frequent ear infections (>5/yr)
[ ] Urinary tract infections
[ ] Frequent headaches
[ ] Heart Murmur
[ ] Seizures/Epilepsy
[ ] Anemia/low blood count
[ ] Loud snoring
[ ] Pneumonia
[ ] Depression/emotional problems
[ ] RSV/Bronchiolitis
[ ] Eating disorder/Anorexia
[ ] Stomach problems/reflux
[ ] Poor school performance
[ ] other explain below

Explain _____
_____
_____
_____

Family History (This should include grandparents, aunts, uncles, etc. Please indicate which relative by illness)

[ ] ADD / ADHD _____
[ ] Alcoholism/Drug Abuse _____
[ ] Allergies-nasal;Environmental,Food _____
[ ] Arthritis _____
[ ] Asthma/RAD _____
[ ] Autoimmune Disorder-Lupus,Psoriasis _____
[ ] Blood Disorder-Hemophilia,Sickle Cell, Bleeding Problems _____
[ ] Bed Wetting _____
[ ] Cancer _____
[ ] Complications from Anesthesia _____
[ ] Congenital Birth Defects _____
[ ] Congenital Heart Disease-VSD, Tetrology, Single Ventricle _____
[ ] Developmental Delay/Disorder-Austim, Speech Delay _____
[ ] Diabetes- Onset under 25 yrs _____
[ ] Down's Syndrome _____
[ ] Ear Problems-Cholesteotoma, Frequent Ear Infections _____
[ ] Eczema _____
[ ] Epilepsy/Seizures/Convulsions _____
[ ] Eye Problems-Crossed eye, Glaucoma, Cataracts _____
[ ] Family Violence/Domestic Abuse _____
[ ] Gastrointestinal Problems-Ulcers, IBS, Reflux, Inflammatory Bowel _____
[ ] Hearing Loss from birth-Congenital deafness ____ _____
[ ] Heart Disease-Under 50 yrs. _____
[ ] High Blood Pressure _____
[ ] High Cholesterol/Triglycerides _____
[ ] Immune Disorder _____
[ ] Infant Death-SIDS _____
[ ] Kidney Disease/problems _____
[ ] Learning Disabilities _____
[ ] Liver Disease-Jaundice _____
[ ] Mental Illness-Depression, Anxiety _____
[ ] Mental Retardation _____
[ ] Migraines _____
[ ] Obesity _____
[ ] Schizophrenia _____
[ ] Scoliosis _____
[ ] Sexually Transmitted Disease-AIDS, Syphilis _____
[ ] Stroke-Under 50 yrs. _____
[ ] Sudden Athletic Death-Arrhythmia _____
[ ] Tuberculosis (TB) _____
[ ] Thyroid/Hormone Problems _____
[ ] Rare Disease-Cystic Fibrosis, Multiple Sclerosis, Muscular Dystrophy, Neurofibromatosis _____
[ ] Explanations/Other Family Health Issues _____
_____
_____
_____
_____
_____
_____
_____

Please list any health concerns you have _____
_____
_____

Please list any medication your child is currently taking _____
_____
_____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No

The following individuals are able to authorize medical treatment for my child(ren) in my absence:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

P**arent or Guardian Signature** _____ **Today's Date** _____