NEW PATIENT HISTORY

Child's name____ **DOB:** ________________

House Hold: Please list all those living in the child's home

Name Relationship to child DOB Health Problems

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Birth Wight: _______________ Vaginal______________ C-section_______________

Maternal History: ____

During Pregnancy: Tobacco Use______________ Drug Use _______________ Alcohol Use____________

Did you baby go home from hospital with you? _______________________

• Does your child have any Chronic Health Conditions? □ No □ Yes o If yes, what for?

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• Has your child been in the hospital overnight since he/she was born? □ No □ Yes o If yes, when and what for?

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• Has your child had any surgeries? □ No □ Yes o If yes, when and what for?

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• Does your child have any ongoing medical problems (e.g.: asthma, recurrent ear infections, diabetes)? □ No □ Yes o If yes, please list and age

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• Are there any other doctors who help take care of your child (e.g.: allergist or ear-nose-throat doctor)? □ No □ Yes o If yes, please list

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• Does your child have any allergies? Please list. □ Medication □ Pets □ Foods □ Seasonal, Others:

____

• Does your child take any medications? (Please include vitamins) □ No □ Yes, Please list:

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• Has your child received immunizations: □ Yes, up to date □ No, none □ Has received some but not all

• Any concerns about your child? Physical, Mental or emotional development behavior in school, academic? □ No □ Yes o If yes, when and what for?

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• Who does your child live with? ____

• Parents are: □ Married □ Single □ Separated □ Divorced