New patient medical history

Patient's name: _____ Patient's age: _____

Please state the reason or medical problem that brings you here:

_____

Is this your first child? _____ If not, how many children do you have? _____

Mother's age at birth: _____

How long was the pregnancy in weeks? _____

Were there any problems during the pregnancy/delivery? No _____ If yes, please list:

_____

Did the baby have any problems during his/her hospital stay? _____

How long was the baby in the hospital after birth? _____

Please list any medications taken during pregnancy: _____

_____

Were prenatal vitamins taken, and if so, when were they started: _____

If delivery was by c-section, please indicate why a c-section was performed:

_____

What was your child's birth weight? _____

Please list any medical problems that your child has: _____

_____

Please list any major illnesses/hospitalizations: _____

_____

Please list any specialists that your child has seen: _____

What do you feed your child? (check all that apply): __ formula: what type? _____ __ breast milk

__table food. How much? _____ oz how often? _____ hr

What type of bottle/nipple do you use? __regular __ pigeon __ Haberman __other:_____

Please list any operations or procedures:

Date	procedure	Surgeon's name	Where was it performed?

Please list all medications (current and past). Please include vitamins, herbal supplements, over the counter and prescription medications

Name	Dose	frequency	Still taking?	purpose

Please list any drug or food allergies and reactions: _____

_____

Is your child up to date on all immunizations: _____

Mother Age: _____ Current Health:_____ Past Health Problems: _____

Occupation: _____

Father Age: _____ Current Health:_____ Past Health Problems: _____

Occupation: _____

Marital Status of Parents:__ Married __divorced __single

Other Children in Family: Healthy or Medical Issues? _____

Are there cultural or religious practices that might affect your child's medical care? ___no ___ yes

If yes, please explain (e.g. blood transfusion, dietary rules, etc.): _____

Is there tobacco use in/around your household? __ no __ yes

Are there any pets in the household? __ no __ yes

Is there a history in the family/a blood relative of:

Birth Defects/Genetic Problems __ no __ yes

Cancer __ no __ yes

Diabetes __ no __ yes

Heart Attack __ no __ yes

Hepatitis __ no __ yes

High Blood Pressure __ no __ yes

High Cholesterol __ no __ yes

Learning Disability __ no __ yes

Mental Illness __ no __ yes

Seizures __ no __ yes

Thyroid Problems __ no __ yes

Is there anything else that you would like to tell the doctor? _____

Pediatrician name:_____ Phone number: _____ Fax number: _____

Preferred pharmacy: _____ Phone number: _____

Signature_____ Date:_____