ABC Pediatrics New Patient Health History

Name:_____ **date of birth**_____

Referral Information

Child's Primary Doctor_____
Date of Last Physical exam_____
Any Concerns:_____

Current Medications: (including non-prescriptions)

Medication Dose Frequency

Allergies **Reaction that occurs with exposure**

Pregnancy History

Problems during pregnancy with your child (please circle)
Diabetes High Blood Pressure Swelling Other

if "other" please describe_____

Medications or other substance (ie; smoking, alcohol, etc) taken during pregnancy:

Duration of pregnancy (Circle)
Full Term Premature (<37 weeks) Overdue (>40 weeks)

Delivery (Circle) Vaginal Cesarean
If Cesarean, why was this done:

Please list any other medical problems or concerns around delivery

Birth History
Birth weight:_____ Pounds:_____ Ounces_____ Birth Length_____ Inches_____
Feeding (circle)
Breastfeeding only Breast feeding w/formula Formula (Type)_____
Development History
Do you feel your child's development is (circle) Normal Abnormal

Patient's Name_____ **date of birth**_____

Family History

Check if the following conditions run in the extended family below:

Conditions	Family member
_____ High Blood Pressure	_____
_____ Heart Problems	_____
_____ High Cholesterol	_____
_____ Diabetes (indicated type 1 (juvenile) or type 2 (adult)	_____
_____ Caner	_____
_____ Birth Disorder	_____

Social History

Name of School:_____

Are there any special resources/classes needed at school?

Describe:_____

Hospitalizations

Year	Hospital	Illness	Length of stay
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

Year	Hospital	Surgery type	Complications
_____	_____	_____	_____
_____	_____	_____	_____

Fractures None Location/date_____

Review of Systems: (circle all that apply)

HEENT-	vision problems	frequent colds
	frequent ear infections	frequent sinus infections
	strep throat	
Heart-	murmur	
Lungs-	asthma	bronchitis
	pneumonia	
Abdomen-	constipation	diarrhea
	reflux	
GU-	kidney infections	bed wetting
Neurological-	delays	seizures
Muscular/skeletal-	joint pain	scoliosis
	eczema	birthmarks
	scars	
Psychological	mood behavioral problem	ADD
	academic concerns	sleep problems

Signed_____ Date_____