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NEW PATIENTS

Child's Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY

Birthplace _____ Birth weight _____ Length _____ Head Circumference _____

Birth Complications: _____

Allergies: _____

Prior Hospitalizations: _____

Prior Surgeries: _____

Underlying illnesses: _____

CURRENT MEDICATIONS: (Please include Over the Counter, Herbal and Nutritional Supplements): _____

FAMILY HISTORY (If positive, give relationship to child-M, F, S, B, MGM, MGF, PGM, PGF):

☐ ADD/ADHD	☐ Heart Disease
☐ Alcohol/Substance Abuse	☐ High Blood Pressure
☐ Allergies	☐ Infant Death
☐ Anemia	☐ Kidney Disease/UTI
☐ Asthma	☐ Learning/ School Difficulties
☐ Birth defects	☐ Mental Illness
☐ Bleeding/ Blood Disorders	☐ Mental Retardation
☐ Bone/Joint Disorders	☐ Migraine Headaches
☐ Cancer	☐ Nerve/Muscle Disorders
☐ Cholesterol Elevation	☐ Obesity
☐ Cystic Fibrosis	☐ Osteoporosis
☐ Diabetes	☐ Skin Disorders
☐ Down Syndrome	☐ Stroke
☐ Epilepsy/Seizures	☐ Sudden Death
☐ Hearing Loss	☐ Thyroid Disease
☐ Heart Attack < 55yrs male _____	☐ Tuberculosis
☐ < 65 yrs female _____	☐ Other

SOCIAL HISTORY

Diet restrictions:	Seatbelt/Car seat used routinely: Y N
Caffeinated drinks:(circle) Daily, Occasional, None	Sunscreen used routinely: Y N
Exercise level:(circle) Daily, Occasional, None	Insect repellent used routinely: Y N
Sporting activities:	Guns present in home: Y N
Parents' marital status:	Years in school: School name: _____
Child lives with:	Pool at home: Y N
Animals: Y N Type: _____	Parent(s) Occupation: (please indicate which parent) _____
Smoke exposure: Y N	Parents born in foreign country: Y N
Smoke/CO Detectors in home: Y N	If yes, name of country: _____

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