Forest Hills Pediatrics New Patient History

Child's Name: _____Date of Birth: _____
Person Completing Form:_____ Today's Date: _____
Please provide any additional comments or information at bottom of form.

Medication or Food Allergies *List any medications or foods that cause an allergic reaction in your child (i.e. rash, difficulty breathing)*	
Medication/Food	***Reaction***

Surgeries and Hospitalizations	
Operation/Hospitalization	***Month/Year***

Serious Injuries, Accidents or Fractures	
Injury/Fracture	***Month/Year***

Medications/Vitamins/Herbal Supplements	
Medication	***Dose/Frequency***
i.e. Zyrtec	*5 mg once daily*

Do any smokers live in the home? ☐Yes ☐No

Childcare/School:

Past Medical History *Check if your child has had any of the following.*	
☐ Child is Adopted	☐ Environmental allergies
☐ ADHD	☐ Asthma
☐ Anxiety	☐ Constipation
☐ Depression	☐ Developmental Delays
☐ Diabetes	☐ GI Reflux (GERD)
☐ Hearing Problems	☐ Prematurity
☐ Seizures	☐ Recurrent strep throat
☐ Urinary tract infections	☐ Recurrent ear infections
☐ Chicken Pox	☐ Vision Problems
☐ Other (*please describe*):	

Who lives with your child?	
Name	***Relation to child***

Are there parents or siblings who do not live in the home? (Please describe) ☐Not Applicable

If parents are not living together, or if the child does not live with his/her parents, please describe the child's custody status: ☐Not Applicable

Additional information:_____
_____
_____
_____

Staff Initials: _____