Patient Front Sheet

Today's Date:_____

Children's Information

Last Name, First Name	Sex	Date of Birth	Last Name, First Name	Sex	Date of Birth
_____		___/_____	_____		___/_____
_____		___/_____	_____		___/_____
_____		___/_____	_____		___/_____

Parent/Guardian Information

Parent/Guardian (Guarantor) Date of Birth

_____ ___/___/_____

Relationship to Patient:

_____

Home Address:

_____

City:

_____ Zip: _____

Preferred #: (_____)_____

Circle one: ☐ Mobile ☐ Home

Email: _____

Parent/Guardian Date of Birth

_____ ___/___/_____

Relationship to Patient:

_____

Home Address:

_____

City:

_____ Zip: _____

Preferred #: (_____)_____

Circle one: ☐ Mobile ☐ Home

Email: _____

As a member of our practice, you will automatically be enrolled in text, emails, and phone calls. If you wish to opt out to any of the following, please inform our office.

Occupation:_____

Employer: _____

Work Phone: (_____)_____

Occupation:_____

Employer: _____

Work Phone: (_____)_____

Parents' Marital Status: _____

In case of emergency, notify (other than parent):

Name: _____ Phone Number: (_____) _____

Relationship to Patient: _____

Name of insurance: _____

Who referred you to our practice?: _____

Preferred Pharmacy (Name, Address and Phone number): _____

_____

PEDIATRIC PATIENT HISTORY

Today's Date:_____

Patient's Name: _____ Date of Birth: _____

Informant (Relationship to patient): _____

Previous Pediatrician: _____ Location: _____

MOTHER'S HISTORY: (circle the appropriate response)

PREGNANCY:

1. Illnesses	☐ NO	☐ YES
2. Drugs	☐ NO	☐ YES
3. Prematurity	☐ NO	☐ YES
4. Hospitalization	☐ NO	☐ YES
5. Bleeding	☐ NO	☐ YES
6. Smoking	☐ NO	☐ YES
7. Drinking	☐ NO	☐ YES

LABOR AND DELIVERY:

9. Cesarean Section	☐ NO	☐ YES
10. Prolonged Labor	☐ NO	☐ YES
11. Complications	☐ NO	☐ YES

NEWBORN STAY:

1. Prolonged Stay	☐ NO	☐ YES
2. Jaundice	☐ NO	☐ YES
3. Other:_____		

Comments on **YES** responses: _____

PATIENT'S HISTORY

1. Allergic to_____		
a. medication	☐ NO	☐ YES
b. other	☐ NO	☐ YES
2. Childhood Illnesses		
b. Ear infections	☐ NO	☐ YES
c. Asthma	☐ NO	☐ YES
d. Frequent colds	☐ NO	☐ YES
e. Stomach problems	☐ NO	☐ YES
f. Other_____		

3. Hospitalizations	☐ NO	☐ YES
4. Surgeries	☐ NO	☐ YES
5. Dental Problems	☐ NO	☐ YES
6. Injuries, Poisonings	☐ NO	☐ YES
8. Vaccine reactions	☐ NO	☐ YES
9. Current medications	☐ NO	☐ YES
10. Vision or hearing problems	☐ NO	☐ YES
11. Daycare/Preschool	☐ NO	☐ YES
12. Learning or developmental problems?	☐ NO	☐ YES

Comments on **YES** responses: _____

_____

FAMILY MEDICAL HISTORY: (includes mom, dad, aunts, uncles, and grandparents)

Are there any immediate family members who have a special medical problem or who are on special medications? ☐**NO** ☐**YES**_____

Are there any immediate family members who have died of medical causes? ☐**NO** ☐**YES**

IF SO, WHO? _____ **CAUSE?**_____

Are there any immediate family members who have these conditions? If yes, which members?

Allergies, asthma, eczema	☐NO	☐ YES	_____
High cholesterol or triglycerides	☐NO	☐ YES	_____
Heart Disease	☐NO	☐ YES	_____
High Blood Pressure	☐NO	☐ YES	_____
Endocrine Disorders (Diabetes, thyroid disorder)	☐NO	☐ YES	_____
Anemia, blood disorder, bleeding problems	☐NO	☐ YES	_____
Autoimmune Disease (Lupus, Rheumatoid Arthritis)	☐NO	☐ YES	_____
Tuberculosis, positive skin test	☐NO	☐ YES	_____
Cancer	☐NO	☐ YES	_____
Seizure or convulsion disorder	☐NO	☐ YES	_____
Vision, hearing or speech problems	☐NO	☐ YES	_____
Learning disabilities or developmental delay	☐NO	☐ YES	_____
Birth Defects	☐NO	☐ YES	_____
Domestic Violence	☐NO	☐ YES	_____
Cigarette Use	☐NO	☐ YES	_____
Any psychological or mood disorders, (Depression, anxiety, schizophrenia)	☐NO	☐ YES	_____