Welcome to Pediatric Place
New Patient Information and Medical History

Child's Full Name ______________________________ Date of Birth ____________

Previous Doctor(s) ________________________ Phone # ________________
Address ____
How did you hear about us? ____

Mother's Name ____________________
Mother's Occupation __________________
Does mother live with child? [ ] Yes [ ] No

Father's Name ______________________
Father's Occupation ____________________
Does father live with child? [ ] Yes [ ] No

Legal Guardian Name ______________
Is the child adopted? [ ] Yes [ ] No
Is the child in foster care? [ ] Yes [ ] No

Names of siblings/Birthdates ______________ ___/___/___
______________ ___/___/___
______________ ___/___/___
______________ ___/___/___

Mother's age at birth _______
Birth weight _______lbs _______oz
Was baby born early? [ ] Yes [ ] No

Type of delivery [ ] Vaginal [ ] C-section
Number of days baby stayed in hospital after birth _____

Check if mother had any of the following during pregnancy or delivery:
[ ]Infections [ ]Diabetes [ ]Drug/alcohol use [ ]Cigarette use [ ]Early labor [ ]Other complication

Medical History

	Yes	No	Explain (include dates if known)
Does your child have any chronic conditions or diseases?			
Hospitalizations?			
Surgeries?			
Emergency room visits?			
Food allergies?			
Medication allergies?			
Immunization reactions?			

Check if your child has <u>ever</u> had any of the following:

- ☐ Chickenpox
- ☐ Frequent ear infections (>5/yr)
- ☐ Urinary tract infection
- ☐ Frequent headaches
- ☐ Heart murmur
- ☐ Seizures/Epilepsy
- ☐ Anemia/low blood count
- ☐ Loud snoring
- ☐ Pneumonia
- ☐ Depression/ emotional problem
- ☐ RSV/Bronchiolitis
- ☐ Eating disorder/Anorexia
- ☐ Stomach problems/reflux
- ☐ Poor school performance
- ☐ Other:

Please list any health concerns you have ____
____
____

Please list any medications your child is currently taking ______________________________
____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No [ ] Not sure

Family History
Check if a family member *other than the child* has ever had any of the following – WHO?

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease before age 55
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Sudden death from unknown cause
- ☐ Complications from anesthesia
- ☐ Schizophrenia
- ☐ Depression
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Tuberculosis (TB)
- ☐ Sickle cell disease

Parent or Guardian Signature________________________ Today's Date ____________