

NEW PATIENT HISTORY FORM

Patient's Name: _____ **Birth** date: _____ Date of **Office Visit**: _____

Referring Physician: _____ Other Physician(s) seeing this patient: _____

Reason for today's visit: _____ Is this a 2nd opinion? [] No [] Yes

* **Birth/Infancy History:** Birth Weight: _____ Fullterm? [] Yes [] No if no, how early? _____

	No	Yes		No	Yes	Now?
Problems with pregnancy or delivery?		What?	Breastfed?		How long?	
Stayed in the NICU?		How many days?	Bottlefed?		How long?	
Needed oxygen but no breathing tube?		How many days?	Pacifier use		How long?	
Needed apnea monitor?		How many days?	Passed infant hearing test			
Needed breathing tube, ventilator?		How many days?	If no, passed retest?			

Other or additional details: _____

***Has the child been hospitalized?** [] No [] Yes Had surgery? [] No [] Yes If yes, why and when? _____

***Has the Patient had Problems with Anesthesia:** [] No [] Yes explain _____

***History/Review of systems: Please check if your child has/had any of the following medical problems? (If yes, please explain)**

	No	Yes	In past		No	Yes	In past
Congenital Heart Disease				Developmental Delay			
Heart Murmur				ADD / ADHD			
Needs antibiotics for dental procedures				Seizures or Neurological Problems			
GE Reflux (frequent throwing/spitting up)				Thyroid or Blood Sugar Problems			
Other Stomach, Bowel or Digestive Problems				Bleeding problems (other than nosebleeds)			
Feeding Tube				Nosebleeds			
Asthma (diagnosed)				Sickle Cell Disease / Trait			
Wheezing (no asthma)				Allergies / hay fever / eczema			
Recurrent Croup				Immune Deficiency			
Other Pulmonary or Lung Problems (BPD, etc)				Skin: hemangioma, café au lait spots, Psoriasis, etc			
Cleft lip or palate				Kidney or Bladder Problems			
Eyes: crosseyed, glasses, ROP, etc				Are immunizations current?			NA

Other or give details for "yes" answers above: _____

Current Mediations: _____

* **Family History: Check if a family member has/had the following medical problems, give relationship to child and explain:**

Problem	No	Yes	Who and explain	Problem	No	Yes	Who and explain
Bleeding				Sickle Cell Disease			
Anesthesia				Ear issues, hearing loss			
Nose, Throat				Allergies, asthma			

Other or additional explanation _____

***Social History:**

Is the child: In daycare? [] No [] Yes Started when? _____ Days per week _____ Hours/day _____ # kids in class _____
 In school? [] No [] Yes Grade _____ Name of school _____

Does any family member smoke? [] No [] Yes Who? _____ How much? _____ In home? [] No [] Yes

In car? [] No [] Yes _____ Other children in home (age, sex): _____

Are any family members patients in this practice? [] No [] Yes Who? _____

Who does the child live with? _____ Legal Guardian Name(s): _____

PLEASE FILL OUT COMPLETELY

Reviewed by M.D.: _____

