NEW PATIENT HISTORY FORM

Patient's Name: ______________________ **Birth** date: ____________ Date of **Office** Visit: ___________

Physician who referred you: ____________________ For:_________________ Other Physicians: ________________________________

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? _____________

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***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:____

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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 ____

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***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): ___________________