

Pediatric New Patient Information

Name: _____

Date of Birth: _____

Who previously cared for your child? _____

When was he/she last seen? _____

Is your child on many medications/vitamins/herbs? Please list:

Does your child have a history of (please circle all that apply):

Asthma

Headaches

Recurrent infections

Allergies

Heart Defects

Vision/hearing Problems

Diabetes (Type I/ Type II)

Hypertension

Emotional/Behavioral Issues

Other:

Is there a family history of :

Asthma

Birth Defects

Cancer

Allergies

Bleeding Disorder

High Blood Pressure

Diabetes

Blood Clots

High Cholesterol

Other:

Allergies (please list reaction as well):

Who lives with your child? _____

Does anyone smoke inside the home? _____ YES _____ NO

What are your child's favorite activities/sports? _____

Any concerns about your child's nutrition? _____ YES _____ NO

Please explain _____

Is your child up to date on vaccinations? *(Please provide the office with a copy of immunization records at your earliest convenience)* _____ YES _____ NO

Has your child had any surgeries? (Please list type of surgery and dates /age)

Do you have city or well water? _____

Has your child ever been to a dentist? _____ YES _____ NO

Name of Dentist _____

Any complications during pregnancy or delivery? _____ YES _____ NO

Please explain _____

If female, has she started her period? _____ YES _____ NO _____ Age of onset

Do you have concerns about (circle all that apply):

Smoking

Sleeping Habits

Drinking Alcohol

Drug Use

Obesity

Being Bullied by Peers

School Performance

Sexual Activity

Other: