New Patient Information

Name:______________________________ Date of Birth:___________________________
Referred By: __________________________

DRUG ALLERGIES:____
Type of reaction: _______________________

OTHER ALLERGIES (food or environmental):___________________________
Current medications: ____
Prior physician:
____

Birth History:

Birth weight_____________________ Hospital/City:_________ _________________
Delivery: __On time ___Premature (how many weeks_________) ____NICU
___Breech ___Vaginal ___C-Section
Please list any prenatal or postnatal complications:___________________________________
____
Any Maternal alcohol or tobacco use in pregnancy? ____Yes ____No

Developmental History: Please note at what age your child:

_____Lifted head
_____Rolled over
_____Crawled/cruised
_____First Word
_____Two word sentences
_____Learn to write name
____Smiled
____Sat up independently
____Mama/dada
____Walked independently
____Potty trained
____Learn to read

Medical Problems: please circle those that apply

- Asthma/wheezing/bronchiolitis
- Gastroesophageal reflux (GERD)
- Recurrent ear infections
- Recurrent colds
- Anemia (Low iron/blood count)
- Snoring
- ADHD
- Constipation or diarrhea
- Chronic headaches
- Speech/Hearing problems
- Sinus problems
- Recurrent stomachaches
- Eczema or other skin problem
- Weight loss/weight gain
- Scoliosis
- Vision Problems/Glasses
- Urinary Tract Infections
- Accidental day or night time wetting
- Recurrent Throat Infections
- Acne
- Autism or other developmental disorders
- Any other medical problems: Please describe_____________

Medical History:
Hospitalizations/Location/Year/Reason: ____
____

Surgical History:
Please list any surgeries or broken bones/Year: ______________________________

Social History:
Who lives in home with child?____
_____Daycare ____Home school ____Private/public school
Does anyone in the home smoke, abuse alcohol or drugs?
_________________________ Do you suspect that your child smokes, uses alcohol or drugs? _____________________ Extra curricular activities:
____ How many hours per day does your child spend on computer or tv? _________________ How much exercise or vigorous activity does your child have per day? ______________ Do you have any concerns regarding your child's eating habits/weight or height? _____ Do you have any concerns regarding your child's appearance or attitude? ____________ Do you have any concerns regarding your child's grades or academic appearance? ____ Do you speak more than one language at home? If yes what other languages__________

Family History: Please list age and health of immediate family members:
Mother: ____
Father: ____
Siblings: ____
Are any of your children or immediate family members deceased? ______________

Please check and list who is affected by the following conditions:

- Asthma
- Alcoholism/Drug addiction
- Allergies
- Blood disorders including anemia
- Birth defects
- Behavioral disorders including autism,ADHD
- Cancer
- Diabetes (Type I or II)
- Genetic defects
- Heart/cardiovascular disease
- High blood pressure
- Immune deficiency (including HIV/AIDS)
- Kidney disease
- Mental/psychiatric disorder
- Autoimmune disease
- Seizures
- Sudden death
- Thyroid disease
- Eye abnormalities including cataracts, vision problems, blindness
- Other____

Parent/guardian signature: ________________________ Date: ____________________

Physician reviewed/signature: ______________________ Date: ____________________