Date______________

Pediatric New Patient History

Patient Name:____ Date of Birth:___________
Preferred name____

Birth History
Birth Weight____________ Birth Length__________Born at Term or Before Term __________
Birth Place:___________________________________City, State________________________
Problems during pregnancy:____
Type of Delivery: Vaginal Caesarean
Problems during birth____
Breast fed, how long__________________ Formula, which kind________________________

Surgical History: Has your child had any of these? Please circle for Yes:

Appendectomy	Eye Surgery	Lymph Node Biopsy
Ear Tubes	Hernia Repair	Tonsillectomy
Circumcision	Dental Surgery	

List any other surgical procedures____

Family History: Circle if you know that a family member has/had any of these conditions. Place M for mother's side of the family or F for father's side, if known

Asthma	Birth Defects	Cancer	Suicide
Heart Disease	High Blood Pressure	High Cholesterol	Urinary problems
Learning problems	Mental Illness	Stroke	Substance Abuse
ADHD	Allergy	Blood clots	Sickle Cell Disease
Bowel disease	Migraines	Tuberculosis	HIV/AIDS
Hepatitis	Skin Cancer	Depression	Diabetes

Medical History: Has your child had any of these? Please circle for Yes

ADD/ADHD	Colitis/Bowel disease	Heart Murmur	Strep Throat
Allergies	Congenital disease	Hearing Problems	Scoliosis
Anemia	Diabetes	HIV/AIDS	Seizures
Anxiety	Ear Infections	Jaundice	Sickle Cell
Asthma	Eating problems	Lead Poisoning	Tuberculosis
Cancer	Eczema	Meningitis	Urinary infections
Chicken Pox	Headaches	Pneumonia	Vision problems

List any other medical problem____
Medical Specialists____

Pediatric Wellness History

Current Medications, Supplements, Vitamins

____
____

Allergies

____
____

New Conditions or Surgeries since last seen

____
____

Nutrition/Growth

Type of milk: Cow Soy Nut How many cups/day________
Type of water: Bottled Tap How many cups/day________
Concerns about eating habits____

How many hours of sleep at night__________ day__________Are weekends different___________
Concerns about sleep____

How many hours per day of exercise_____ What types___________________________________

Concerns about growth____

Development: Circle areas of concern or write below
Gross motor or fine motor skills Communication Problem Solving Social skills Behavior

____
____
____

Media Use: How many hours/day:
TV________ Computer/tablet_________ Cell Phone________ Video games_________

Education
Daycare, School or Home____
Grade level_________
Concerns____

Pediatric Wellness History (page 2)

Social History:

Who lives at home with child:

Adults ____

Children (ages) ____

____

Other ____

List care givers outside of home____

Are parents: Married Partnered Separated Divorced Never Married

Parent Occupation______________________Parent Occupation__________________________

Has the child been exposed to:

Tobacco Vape Marijuana Alcohol Other drugs

Are guns in the home_____ If guns are in the home, are they stored?_____________________

Has the child been exposed to violence____

Review of Systems:

Does your child have any of the following:

Fever/chills/excessive sweating	Headaches	Speech problems
Unexplained weight loss/gain	Weakness/clumsiness	Sleep problems
Cross eyes/squinting/vision issues	Muscle/joint pain/stiffness	Depression
Sneezing/allergies/itchy eyes	Hearing problems	Anxiety
Mouth breathing/snoring	Skin rashes/unusual moles	Stress
Frequent runny noses	Menstrual problems	Substance abuse
Easy Bruising/bleeding	Teeth/Mouth problems	Harmful behaviors

Any other items you feel are important for us to know about your child?

____

____

____

Name of person completing the form____

Relationship to child____

Date_______________