Pediatric New Patient Form

WHITE HOUSE CLINICS

Child's Name: | Child's Date of Birth:

Name and relationship of person filling out this form:

BIRTH HISTORY (Complete only for children less than 1 year)

Child's previous Health Care Provider:

Did the mother have problems during the pregnancy (high blood pressure, high sugar, etc)?

Did the mother take any medicines, drugs, or smoke cigarettes during pregnancy? Yes ☐ No ☐

If yes, please explain:

Was the Child's birth: Vaginal ☐ C-Section ☐ Don't Know ☐

Did the mother receive antibiotics during delivery? Yes ☐ No ☐ Don't know ☐

Did the mother test Group B Strep positive? Yes ☐ No ☐ Don't know ☐

Is the baby: formula fed ☐ breast fed ☐ | Did the baby receive the Hepatitis B shot in the hospital? Yes ☐ No ☐ Don't Know ☐

Did the child go home from the hospital with mom? Yes ☐ No ☐ Don't Know ☐

SECTION 1: (Complete for all children)

In which hospital was the child born? | How much did the child weigh at birth?

Was the child born: On time ☐ Early ☐ | If early, how many weeks early:

Did the child have problems after birth - on oxygen, jaundice, on antibiotics, etc.?

PAST MEDICAL HISTORY (Complete for all children)

Are immunizations (shots) up to date? Yes ☐ No ☐ Don't Know ☐

* Do you have a shot record? Yes ☐ No ☐ | Where have shots been given in the past?

Has the child ever had a high fever, screaming fit, or seizure after shots? Yes ☐ No ☐ Don't Know ☐

▶ Please list any allergies to medicine or food:

▶ Please list any medicine the child takes every day:

Has the child ever stayed in the hospital overnight? Yes ☐ No ☐ | If yes, please explain why:

Has the child ever had any surgeries? Yes ☐ No ☐ | If yes, please explain why:

Identify any medical problems the child has (example: asthma, allergies, or ADHD): None ☐

Do you have any concerns about the child's behavior or development? Yes ☐ No ☐

If yes, please describe:

(More on back...)

SOCIAL HISTORY

Where does the child live: House ☐ Apartment ☐ Mobile Home ☐ Other ☐

Does the home have heat? Yes ☐ No ☐ | Does the home have running water? City ☐ Well ☐ Cistern ☐ None ☐

Please list all household members:

Name:	Age:	Relationship with child:

Has the child moved recently? Yes ☐ No ☐ | If yes, from where:

Does the child live in or regularly visit a house more than 30 years old? Yes ☐ No ☐

Does a parent have custody of the child? Yes ☐ No ☐ | If No, who does?

Does either parent / guardian work outside the home or are they in school? **Mom:** Yes ☐ No ☐ **Dad:** Yes ☐ No ☐

Where do they work or where do they go to school? **Mom:**

Dad:

Does the child attend daycare or a babysitter? Yes ☐ No ☐

Name of daycare or how many other kids at sitter:

Does anyone who lives in the home smoke? Yes ☐ No ☐ Does anyone who regularly cares for the child smoke? Yes ☐ No ☐

Is the child in school? Yes ☐ No ☐ | Name of school and grade level:

Has the child ever been held back? Yes ☐ No ☐ | What grade:

Was the child born or have they traveled outside the country? Yes ☐ No ☐

Is the child regularly around anyone who travels outside the country? Yes ☐ No ☐

Has any family member or close contact had tuberculosis (TB) or a positive TB skin test? Yes ☐ No ☐ Don't Know ☐

Are there guns in the home? Yes ☐ No ☐ | Are they locked? Yes ☐ No ☐ Don't Know ☐

Does the child ride in a carseat: Yes ☐ No ☐ | Does the child wear seat belts: Yes ☐ No ☐

Do you have any concerns about the child's safety or wellbeing in their home: Yes ☐ No ☐

FAMILY HISTORY

Please check if any of the following applies to the child's parents, siblings, aunts/uncles, grandparents, or great-grandparents. **Write who has the medical problem next to the illness.**

- ☐ Asthma
- ☐ Allergies
- ☐ Trouble with Anesthesia
- ☐ Birth defects (such as a hole in the heart, spina bifida, or Down Syndrome, etc.)
- ☐ Cancer
- ☐ High Blood pressure
- ☐ High cholesterol
- ☐ Heart attack under age 50
- ☐ Diabetes
- ☐ Blood disorders
- ☐ (hemophilia/free bleeders, sickle cell disease, etc.)
- ☐ Stomach disease (Crohn's, ulcerative colitis, celiac disease, etc.)
- ☐ Thyroid Problem
- ☐ Seizures
- Mental Health issues (depression, anxiety, bipolar, ADHD, etc.)
- ☐ Rheumatologic disease (lupus, rheumatoid arthritis, etc.)
- ☐ Mental Health issues (depression, anxiety, bipolar, ADHD, etc.)
- ☐ Substance abuse (alcohol or drugs)
- ☐ Babies in the family die early of SIDS or other problems
- ☐ Passing Out
- ☐ Sudden Unexplained Death
- ☐ Other