# Pediatric New Patient Form

**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)?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

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

If yes, please explain:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

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?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

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...)
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