New Pediatric Patient History (0-10 years)

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle

Form Completed by:_____ Relationship to Patient:_____
Last First Middle

Medical History

Was your child full-term or pre-term? (4 or more weeks early)

Were there any problems during your pregnancy? ☐Yes ☐No

If yes, what?_____

Did you take any medications during your pregnancy? ☐Yes ☐No

If yes, what?_____

Did your child have any problems right after birth? ☐Yes ☐No

If yes, when and for what problem? _____

Has your child ever stayed overnight in the hospital? ☐Yes ☐No

If yes, what was it and when? _____

Has your child ever had an operation? ☐Yes ☐No

If yes, what and for how long? _____

Has your child taken any long-term medications? (more than 2 weeks) ☐Yes ☐No

If yes, what and long was the medicine continued? _____

Does your child have any medication allergies? ☐Yes ☐No

If yes, what?_____

Are your child's immunizations up to date? ☐Yes ☐No

Please provide us with your child's immunization records

If your child has ever had any of the following problems, please circle the problem and write how old they were when it started or when they had it:

Diagnosis / Condition	Age	Diagnosis / Condition	Age
Asthma		Hearing problems	
Bedwetting/daytime accidents		Frequent headaches	
Bladder or kidney infection		Any heart problem or heart murmur	
Broken bones		Learning problems	
Chicken pox		Problems with eyes or vision	
Concussion		Scoliosis / back trouble	
Depression		Seizures	
Diabetes		Skin problems	
Emotional problems		Sleep problems	
Frequent ear infections		Second-hand smoke exposure	
Other problems:		Speech difficulties	

Please return completed form to the appropriate physician's office.

New Pediatric Patient History (0-10 years), cont'd.

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle

Form Completed by:_____ Relationship to Patient:_____
Last First Middle

Family Health Information

Please circle the disease if anyone in your child's family (parents, grandparents, brother/sister, aunts, uncles, or cousins) has these diseases and write your child's relationship to that person:

Disease	Relationship	Disease	Relationship
Alcohol abuse		High blood pressure	
Asthma		Kidney disease	
Cancer		Learning problems	
High cholesterol		Mental illness, suicide, trouble with nerves	
Deafness		Seizures	
Adult onset diabetes		Stroke	
Childhood onset diabetes		Sudden unexplained death	
Drug abuse		Thyroid disease	
Heart attack (less than 65yrs old)		Other diseases	

Family Information

With whom does your child live? (Mom, Dad, brothers and sisters, other people?)
If split custody, please describe the arrangement.

_____

Has your child had any family problems? ☐Yes ☐No

_____

Does anyone in your child's household smoke? ☐Yes ☐No

_____

Mother's name:_____ Age:_____ Occupation:_____

Father's name: _____ Age:_____ Occupation:_____

Other guardians or caretakers names:_____

Brothers and sisters:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Parent or Guardian Signature: _____ Date:_____

Parent or Guardian name and relationship: _____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.