NEW PEDIATRIC PATIENT FORM

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Child's Name:_____ Date: _____
Parent's Name: _____
Address:_____ Home Phone: _____
City/State/Zip:_____ Cell Phone: _____
Date of Birth: _____ Gender: _____ Referred by: _____

1. Current symptoms, problems, health concerns, and reason for visit: _____
_____
_____

2. Prescription medications: _____

3. Other medications (including over-the-counter meds, supplements, herbs, homeopathic remedies, etc.):
_____
_____

4. Allergies to medications: _____
5. Other allergies (foods, mold, pets, etc.):_____
6. Other food sensitivities:_____
_____

7. Major medical problems (including illnesses, hospitalizations, surgeries, major dental work): _____
_____

8. Describe any traumas, including car accidents, falls, head injuries, sports injuries, fractures (include year occurred):_____
_____
_____

9. Other therapies & treatments (past or present): _____
_____
_____

10. Describe child's sports activities, exercise routine, or level of activity: _____
_____
_____
_____

11. Birth History: Full-term Premature Late C-Section Force-ups/Vacuum Vaginal Delivery (circle)
Any complications during pregnancy, delivery, or post-partum? _____
_____

Older Siblings _____ # Younger Siblings _____
Mother's Age at Delivery: _____ Current Weight: _____
Gestational Age at Delivery: _____ Birth Weight: _____

12. Neonatal History

Breast milk	Yes ☐ No ☐	Colicky	Yes ☐ No ☐
Formula	Yes ☐ No ☐	Failure to Thrive	Yes ☐ No ☐
Bottle fed (either)	Yes ☐ No ☐	Good sleeper	Yes ☐ No ☐
Pacifier	Yes ☐ No ☐	Placed on belly as infant	Yes ☐ No ☐
Strong suck	Yes ☐ No ☐	Favored one side	Yes ☐ No ☐
Frequent Spit-ups	Yes ☐ No ☐		

Age first slept through night: _____ Age started solid foods:_____

13. Please describe sleep habits: _____
_____
14. Orthodontia? When? _____
15. Learning difficulties? _____

16. Past Medical History (please check all that apply)

☐ Seizures ☐ Lyme Disease ☐ Bladder Infections
☐ Asthma ☐ Hepatitis ☐ Kidney Disease
☐ Hives/Eczema ☐ Anemia ☐ Easy Bruising
☐ Bronchitis ☐ Low Blood Pressure ☐ Frequent ear infec.
☐ Ear ☐ Meningitis
☐ Other _____

17. Immunization Status (check if received, indicate most recent year)

☐ MMR _____ ☐ Polio _____
☐ Hep B _____ ☐ Hepatitis A _____
☐ Varicella _____ ☐ Meningococcal _____
☐ Rotavirus _____ ☐ Annual Flu _____
☐ Hib (Haemophilus) _____ ☐ HPV _____
☐ Tetanus/Diptheria/Pertussis (Whooping cough) _____

18. Other Exams (Date/Result)

☐ Food Sensitivity _____
☐ Saliva/Urine Hormone Testing _____
☐ Hair/Urine Heavy Metal _____
☐ Digestive Function/Stool Analysis _____
☐ Neurotransmitter Testing _____

19. Does child use:

☐ Glasses ☐ Contact lenses ☐ Hearing aid

20. Last Dental Exam _____

21. Imaging (Date/Result)

X-ray _____

MRI_____

CT Scan _____

Ultrasound/Sonogram _____

22. Any other abnormal labs or tests? _____

23. Intake

Glasses water per day: _____ Sodas (# per week) – Diet or regular?_____

Dietary restrictions/preferences: _____

24. Family History (please indicate relationship)

Cancer _____
Leukemia _____
Tuberculosis _____
Depression _____
Bipolar/Schizophrenia _____
Substance Abuse _____
Suicide _____
Migraines _____
Seizures _____

Allergies _____
Asthma _____
Eczema _____
Anemia _____
Chronic Lung Disease _____
Thyroid Disease _____
Kidney Disease _____
Diabetes _____
Bleeding Tendency _____

25. List present age of family members & state of health (good, fair, poor). If deceased, list cause of death & age.

Father _____
Mother _____

Sibling(s) _____
_____
_____

Review of Systems

26. Please mark any symptoms that child has experienced in the past year

Change in appetite	☐	Blurry vision	☐	Bloating/belching	☐
Persistent fever	☐	Tinnitus	☐	Flatulence	☐
Hot flashes	☐	Sinusitis	☐	Constipation	☐
Night sweats	☐	Nasal congestion	☐	Diarrhea	☐
Skin rash	☐	Mouth breathing	☐	Hemorrhoids	☐
Change in nails/hair	☐	Shortness of breath	☐	Abdominal pain	☐
Easy bruises/bleeding	☐	Palpitations	☐	Frequent urination	☐
Headaches	☐	Restless legs	☐	Burning w/urination	☐
Migraines	☐	Cold hands/feet	☐	Urinary hesitancy	☐
Double vision	☐	Heartburn	☐	Urinary urgency	☐

27. Please describe any major stressors in patient's life (family, school, living situation, etc.). _____

_____

_____