New Patient Record *(Pediatric)*

Family Information Date_____/_____/_____ Chart No. ☐

Patient_____ DOB __/__/__ Sex: ☐ M ☐ F

Mother's Name_____ Age_____ Phone(H)_____

Mother's Employer_____ Phone(W)_____

Father's Name_____Age_____ Phone(H)_____

Father's Employer _____Phone(W) _____

Referred by_____

Current Medical History

Is your child having any medical problems? ☐ Yes ☐ No

_____

_____

_____

_____

Maternal and Newborn History

Pregnancy (Check problem areas)

☐ Excessive weight gain ☐ Urinary Tract Infect. ☐ Excessive swelling

☐ Rubella (3 day measles) ☐ Toxemia ☐ Venereal Disease

☐ Alcohol/recreational drugs used during pregnancy? ☐ Yes ☐ No

Birth Delivery: ☐ Vaginal ☐ Caesarean Section _____

_____

Baby was ☐ Full Term ☐ Premature Birth Wt. _____

Was labor difficult or prolonged? ☐ Yes ☐ No _____

Was delivery difficult or complicated? ☐ Yes ☐ No _____

_____

Newborn ☐ Breast ☐ Formula _____

☐ Feeding Problems ☐ Colic ☐ Multiple Formula Changes

☐ Blood in Stools ☐ Slow Wt. Gain ☐ Recurring Vomiting

☐ Recurring diarrhea ☐ Jaundice ☐ Other _____

_____

Drug Allergies & Important Diagnoses

Drug Allergies: ☐ Yes ☐ No_____

Illness/Injury _____

_____

_____

History Update (For Office Use)

_____

_____

_____

_____

_____☐ Continued on Back

Family Medical History

	Age	Good Health	Poor Health	Deceased
Father	____	_____	_____	_____
Mother	____	_____	_____	_____
Brother(s)	____	_____	_____	_____
Sister(s)	____	_____	_____	_____
Gr. Parent(s)	____	_____	_____	_____

_____

_____

_____

Check and list family members who have had any of the following conditions:

P-Parent M-Mother GM-Grandmother

F-Father S-Sibling GF- Grandfather

List the Appropriate initial after each.

☐ Trauma: Broken bones, sutures, loss of consciousness, etc. (circle)

_____

☐ Allergies/Drug Allergies_____

☐ Asthma/Eczema _____

☐ Frequent Respiratory infections

_____

☐ Ear Tubes_____

☐ Chronic Cough, recurrent fever, weight loss or night sweats

_____

☐ Tuberculosis_____

☐ Anemia or blood disorders

_____

☐ Stomach or intestinal problems

_____

_____

☐ Diabetes_____

☐ Growth Problem _____

☐ Seizures_____

☐ High cholesterol problems _____

☐ High Blood Pressure_____

☐ Heart attack or stroke before 55

_____

☐ Cancer_____

☐ Hereditary Problems_____

☐ School Problems_____

☐ Emotional/behavior problems

_____

☐ Alcohol or drug abuse_____

☐ HIV_____

☐ Other medical problems:_____

_____

_____

Do you have any other concerns? ☐ Yes ☐ No _____

_____

_____

Signed _____Date_____/_____/_____