



Pediatric New Patient Health History

Date: _____ Person Completing Form: _____ Relationship to Child: _____

PATIENT INFORMATION

Childs Name (First and Last): _____ Sex (circle): M or F Age: _____ Date of birth: / /

REFERRAL INFORMATION

Childs Primary Doctor: _____

REASON FOR VISIT

Concern: _____ When was concern first noticed: _____

What tests have been done for this concern: _____

CURRENT MEDICATIONS

<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>

ALLERGIES

<u>DRUG ALLERGY</u>	<u>REACTION THAT OCCURS WITH EXPOSURE</u>

PREGNANCY HISTORY

Problems during pregnancy with your child (circle): **DIABETES** **HIGH BLOOD PRESSURE** **SWELLING** **OTHER**

If 'OTHER', describe:

Medications or other substances (i.e., smoking, alcohol, etc.) taken during pregnancy:

Duration of pregnancy (circle): **FULLTERM** **PREMATURE (<37 WEEKS)** **OVERDUE (>40 WEEKS)**
WEEKS EARLY: # WEEKS LATE:

Delivery (circle): **VAGINAL** **CESAREAN**

If **CESAREAN**, why was this done:

List any other medical problems or concerns around delivery:

BIRTH HISTORY

Birth weight: _____ pounds _____ ounces Birth Length: _____ inches

Problems around the time of delivery (circle): **BREATHING PROBLEMS** **BLOOD SUGAR PROBLEM** **JAUNDICE** **FEEDING PROBLEMS** **OTHER**

If 'OTHER', describe:

DEVELOPMENTAL HISTORY

Describe your child's development (circle): Normal Abnormal

If **abnormal**, describe and fill in the ages for milestones below. Otherwise skip to "GROWTH/PUBERTY HISTORY" section:

About what age did your child? **ROLL OVER (MOS): _____; SIT ALONE (MOS): _____; CRAWL (MOS): _____;**
(MONTHS=MOS; YEARS=YRS) **WALK (MOS): _____; SAY FIRST WORDS (MOS): _____; TALK IN SENTENCES (YRS): _____**

PAST MEDICAL HISTORY

List any medical problems (Include how long the problem has been treated and physician managing if other than primary doctor):

Check if none

List any prior overnight hospitalizations (approximate age and reason):

Check if none

List any prior surgeries (approximate age and procedure):

Check if none

FAMILY HISTORY

Check if the following conditions that run in the extended family below:

Only need to list conditions that affect mother, father, brother, sister, aunt, uncle, grandmother, or grandfather. Describe maternal (mother's side) with an 'M' or paternal (father's side) with a 'P'.

<u>CONDITION</u>	<u>FAMILY MEMBERS</u>	<u>CONDITION</u>	<u>FAMILY MEMBERS</u>
___ HIGH BLOOD PRESSURE		___ CANCER	
___ HEART PROBLEMS		___ THYROID PROBLEMS	
___ HIGH CHOLESTEROL		___ CALCIUM/BONE PROBLEMS	
___ DIABETES INDICATE TYPE 1 (JUVENILE) OR TYPE 2 (ADULT)		___ EARLY/LATE PUBERTY	
___ PITUITARY GLAND PROBLEMS		___ BIRTH DISORDERS	
___ ADRENAL GLAND PROBLEMS		___ WEIGHT PROBLEMS	

Do any other conditions run in the family?

SOCIAL HISTORY

Who lives at home with your child?

Name of school: _____ Grade level: _____ Average grades: _____

Are any special resources/classes needed at school? If so, describe?

GROWTH/PUBERTY HISTORY

<u>FAMILY MEMBER</u>	<u>AGE</u>	<u>HEIGHT</u>	<u>WEIGHT</u>	<u>AGE OF 1ST PERIOD (FEMALE); EARLY OR LATE BLOOMER (MALE)</u>
MOTHER				
FATHER				
BROTHER / SISTER				
BROTHER / SISTER				
BROTHER / SISTER				

Age of first menstrual cycle or period (**females only**):

Age of breast development (**females only**):

Describe any other concerns with your child's growth OR pubertal pattern:

REVIEW OF SYSTEMS

CHECK BOX IF NO CONCERNS; IF ABNORMAL, DESCRIBE.

CHECK BOX IF NO CONCERNS; IF ABNORMAL, DESCRIBE.

GENERAL: WEIGHT LOSS OR GAIN			SKIN: ACNE		
APPETITE OR ACTIVITY LEVEL			STRETCH MARKS OR DARKENING OF SKIN		
BIRTH DEFECTS			DARKENING SKIN		
EYES: VISION OR EYE DISEASE			BIRTHMARKS OR RASHES		
GLAUCOMA			NEURO: SEIZURES		
ENT: HEARING			HEADACHES		
EAR INFECTIONS			HEAD INJURY OR HEAD SIZE		
SENSE OF SMELL			PSYCH: NERVOUSNESS/ANXIETY		
TEETH			BEHAVIORAL OR HYPERACTIVITY		
LUMPS OR PAIN IN NECK			LEARNING DISABILITY		
SWALLOWING			ENDO: COLD OR HOT EASILY		
CVS: HEART MURMUR			EARLY OR LATE PUBERTY		
BLOOD PRESSURE OR HEART RATE			BREAST DISCHARGE		
PULM: ASTHMA OR BREATHING			ABNORMAL BODY ODOR OR HAIR		

PROLONGED STEROID USE FOR LUNG DISEASE		VAGINAL DISCHARGE	
GI: CONSTIPATION/DIARRHEA		MENSTRUAL PERIODS	
VOMITING		GENITALIA SIZE	
LIVER		EXCESSIVE THIRST	
GU: ABNORMAL GENITALIA		EXCESSIVE HUNGER	
BEDWETTING		EXCESSIVE URINATION	
KIDNEY OR BLADDER		H/O: CANCER	
MS: MUSCLE WEAKNESS		IRRADIATION EXPOSURE	
SWELLING OF HANDS, FEET, OR JOINTS		BLOOD TRANSFUSION	

Are there any other concerns you or your child wishes to be addressed during this visit?

Parent signature: _____

Date: _____

Important reminders for the visit:

- Bring copies or have test reports sent from your doctor.
- If x-rays of the hand were done, obtain a copy and bring to your visit.
- Please bring copies or have growth records sent from your doctor's office.