Today's Date _______________

Pediatric and Adolescent New Patient History (newborn – 12 years of age)

Patient's Name ______________________________ Date of Birth _______________

Male ___ Female ___

Social History

Lives with:

Mother ___ Father ___ Guardian/other _______________________

Siblings (names and ages) ____

Other Medical and Surgical History: Check if your child has a history of these

Recurrent Urinary tract infections ______ Pneumonia ______ Circumcision _____

RSV ______ Croup/need for breathing treatments ______

Hospitalizations ____

Allergy

Seasonal or year-round allergies _____ Food allergies ____

Previous allergy testing _______ Eczema/Atopic dermatitis _____

Medications (as needed or on a regular basis)

____

Allergy to medications/reaction to medication

____

Immunizations

Up to date _____ Copy of immunizations provided today _____Not up to date due to

____

Name: ________________________ MRN _______________ Date ________________

Medical History

Allergies	Yes __ No __	Concussion	Yes __ No __
Asthma	Yes __ No __	Depression	Yes __ No __
Autism Spectrum	Yes __ No __	Heart murmur	Yes __ No __
Breech position	Yes __ No __	HIV/AIDS	Yes __ No __
Cancer	Yes __ No __	Inflammatory bowel disease	Yes __ No __
Diabetes Mellitus	Yes __ No __	Inguinal hernia	Yes __ No __
Food allergy	Yes __ No __	Injuries	Yes __ No __
Hearing loss	Yes __ No __	Jaundice	Yes __ No __
ADHD	Yes __ No __	Meningitis	Yes __ No __
Obesity	Yes __ No __	Urinary tract infection	Yes __ No __
Pneumonia	Yes __ No __	Varicella	Yes __ No __
Headaches	Yes __ No __	Vesicoureteral reflux	Yes __ No __
Hearing loss	Yes __ No __	Vision problems	Yes__ No __
Recurrent Otitis media	Yes __ No __	Scoliosis	Yes __ No __
Seizures	Yes __ No __	STD	Yes __ No __
Sickle Cell Anemia	Yes __ No __	Other ___________________________________	

Surgical History

Adenoidectomy	Yes ___ No ___	Ear tubes	Yes ___ No ___
Appendectomy	Yes ___ No ___	Fracture	Yes ___ No ___
Cleft Palate	Yes ___ No ___	Heart	Yes ___ No ___
Cosmetic	Yes ___ No ___	Inguinal	Yes ___ No ___
Lymph node biopsy	Yes ___ No ___	Tonsillectomy	Yes ___ No ___

Family History **Patient:** ________________________ **MRN:** _________________

Relative: **Condition** **Age of onset**

Mother ____

Father ____

Sister ____

Brother ____

Daughter ____

Son ____

Maternal Aunt ____

Maternal Uncle ____

Paternal Aunt ____

Paternal Uncle ____

Maternal Grandmother ____

Maternal Grandfather ____

Paternal Grandmother ____

Paternal Grandfather ____

Section below for ages 6 and under only

Hospital information

Days in hospital _______ Hospital name ____

Birth Weight _________ Birth Length ____________ Birth Head Circ. __________________

Discharge weight __________ Gestational Age _________

Delivery method Vaginal or C-Section

Duration of Labor __________ Feeding method ____________

APGAR 1 _____________ APGAR 5 ____________ APGAR 10 _________

Birth History: Full term _____ premature ______ weeks

Newborn Period: Uncomplicated __________ Respiratory problems ____

Development: Normal for age_________ other ____________________________________