

NEW PATIENT HISTORY FORM

Date of **First** Visit: _____

Patient's Name: _____ History given by: _____

Date of Birth: _____ Primary Care Physician: _____

Referring Physician: _____ Address: _____

Other Physician(s) seeing this patient: _____

Reason for today's visit: _____

DRUG ALLERGIES: _____ Are immunizations current? _____

* **Birth History:** Birth Weight: _____ Fullterm [] yes [] no if no, how early? _____

Problems with Pregnancy/delivery? [] yes [] no if yes, explain: _____

Number of Days child in hospital: _____ NICU Stay: [] yes [] no if yes, how long? _____

"Breathing tube"/oxygen: [] yes [] no How long? _____ Bililights/lamps: [] yes [] no How long? _____

Breastfeed ___ months Bottlefed ___ months Pacifier Use (circle one): never in past now How long? _____

***Present Medications:** _____

***Prior Medications/dates:** _____

***Previous Hospitalizations/Surgeries/Anesthetics/dates:** _____

***Patient or Family Problems with Anesthesia:** _____

***History: Please check if your child has/had any of the following medical problems? (If yes, please explain)**

[] Heart: () Congenital Heart Disease _____ () Murmur _____
() Needs antibiotics for dental procedures () Other _____

[] Lungs/breathing: () Asthma () Recurrent croup () BPD () Other _____

[] Stomach/bowel/digestive: () Reflux () G-Tube () Other _____

[] Neurological: () Seizures () ADD () Developmental Delay () Other _____

[] Skin: () Eczema () Birthmarks (hemangiomas, café au lait spots, etc) () Other _____

[] Eyes: () Strabismus or crosseyed () Glasses () Other _____

[] Endocrine: () Thyroid disease () Diabetes () Other _____

[] Blood: () Generalized bleeding problems () Nosebleeds () Sickle cell disease/ trait () Other _____

[] Kidney: () Recurrent urinary tract infections () Other _____

[] Allergy/Immunology: () Immune deficiency () Allergies/hayfever () Other _____

[] Other medical problems or further explanation for above _____

* **Family History: Check if a family member has/had the following medical problems, give relationship to child and explain:**

[] Bleeding problems _____ [] Sickle Cell Disease _____

[] Allergies _____ [] Ear, Nose, Throat problems _____

[] Other _____

***Social History:**

Is the child: In daycare? () Yes () No Started when? _____ Days per week _____ Hours/day _____ # kids in class _____

In school? () Yes () No Grade _____ Name of school _____

Does any family member smoke? () Yes () No How much? _____ Who? _____ In home? () Yes () No

In car? () Yes () No

Other children in home (age, sex): _____ Child lives with: _____

Legal Guardian Name(s): _____ Reviewed by M.D.: _____

PLEASE FILL OUT COMPLETELY