New Patient History

Name _____

Date of Birth _____

Birth History

Birth Weight _____

Hospital/City _____

Length of Stay _____

Problems _____

_____

Past Hospitalizations

		length of stay	approx date or age
Reason	_____	_____	_____
Reason	_____	_____	_____
Reason	_____	_____	_____

Past Surgeries _____

_____

Medical Problems – please list below:

_____

_____

_____

Does your child take any medications regularly?

_____

_____

_____

Does your child have any allergies to medications? If yes, please list medication and reaction.

_____

_____

_____

Who may we thank for your referral? _____

CHILDREN'S MEDICAL GROUP, P.A. 1912 W. 35TH STREET AUSTIN TX 78703
PH. (512) 451-5161 FAX (512) 451-1258
www.cmgaustin.com

New Patient History

Has your child ever had the following:

___ Asthma/bronchitis/pneumonia

___ Frequent ear infections

___ Heart problems/murmurs

___ Seizure

___ Loss of consciousness or head injury

___ Bladder or kidney infection

___ Broken bones (age or date _____)

Does anyone in the immediate family have the following:

___ Asthma or frequent bronchitis

___ Severe allergies

___ Heart problems (< 50 yrs of age)

___ Juvenile or Insulin Dependent Diabetes

___ Seizures of other neurologic disorders

___ Malignancy or cancer

___ Thyroid disorder

___ Depression or psychiatric disorder

___ Attention Deficit Disorder or learning disorders

___ Kidney disorders

___ Stomach or bowel disorders

Tell us about your home:

Adults

_____

_____

Relationship to child and place of employment

_____

_____

Siblings and age

_____

_____

_____

Number of smokers: _____

Pets

Indoor: _____

Outdoor: _____

Patient Name _____

Date of Birth _____

and secondary home if applicable:

City/State: _____

Adults

_____

_____

Relationship to child and place of employment

_____

_____

Siblings and age

_____

_____

_____

Number of smokers: _____

Pets:

Indoor: _____

Outdoor: _____

Signature of person filling out this form.

_____