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 ______________________________

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Medical Problems – please list below:

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____

____

Does your child take any medications regularly?

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____

____

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

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____

Who may we thank for your referral? ______________________________

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 occupation

____

____

Siblings and age

____

____

____

Number of smokers: _____

Pets

Indoor: ________________________________

Outdoor: _______________________________

and secondary home if applicable:

City/State: _____________________________

Adults

____

____

Relationship to child and place of employment

____

____

Siblings and age

____

____

____

Number of smokers: _____

Pets:

Indoor: ________________________________

Outdoor: _______________________________

Patient Name ____________________________

Date of Birth ____________________________

Signature of person filling out this form.

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