

## NEW PATIENT INFORMATION SHEET

### NEWBORNS TO AGE 1

Please complete this form carefully and thoroughly. If there are any questions you do not understand, please ask a staff member or physician for assistance. If you would like to inform the doctor of any additional information, please make sure to note the information on this form.

Patient's name:
Name of parent or person completing this form:
How were you referred to this office?

### PREGNANCY AND BIRTH

Mother's age at time of birth:	Is this your first child?	
Did mother have any illness during pregnancy? If Yes, please explain.	Y	N
Did mother take any medications other than vitamins/iron? If Yes, please explain.	Y	N
Was the baby delivered on time? If not, please explain.	Y	N
Did the baby have trouble starting to breathe?	Y	N
What was baby's birth weight?	Apgars (if known):	
Did baby have any problems while in the hospital? If yes, please explain.	Y	N
Please add any additional information you wish to provide about the pregnancy and birth.		

### FAMILY HISTORY

Are the child's parents both in good health? If no, please list each health concern and which parent it applies to.	Y	N			
Has the child or any family member had any of the following illnesses?	Child		Family		If yes, please indicate who.
Anemia	Y	N	Y	N	
Asthma	Y	N	Y	N	
Allergies	Y	N	Y	N	
Diabetes	Y	N	Y	N	
Heart Trouble/Murmur	Y	N	Y	N	
Tuberculosis	Y	N	Y	N	
Mental Illness	Y	N	Y	N	
Drug Problem	Y	N	Y	N	

Alcohol Problem	Y	N	Y	N		
Inherited Illness	Y	N	Y	N		
Cancer	Y	N	Y	N		
Eye Problems	Y	N	Y	N		
Frequent Ear Infections	Y	N	Y	N		
Problems with Urination	Y	N	Y	N		
Problems with Diarrhea or Constipation	Y	N	Y	N		
Seizures	Y	N	Y	N		
AIDS	Y	N	Y	N		
Other	Y	N	Y	N		
Are the child's siblings in good health? If no, please explain.					Y	N
Have any of your children died? If yes, please explain.					Y	N
Please add any additional information you wish to provide about child's family history.						

### SAFETY ENVIRONMENT

Please check your type of residence: <input type="checkbox"/> Private home <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile home <input type="checkbox"/> Other		
Is the hottest temperature of the water in your home less than 120 degrees?	Y	N
Is there a working smoke alarm on each floor in the house?	Y	N
Does your child always use a car seat or seat belt when riding in a car?	Y	N
Are there any smokers in the household?	Y	N
Are there any problems with the condition of your home? (insects, rats, peeling paint, etc.)	Y	N
Do you have a record of your child's immunizations?	Y	N
Please add any additional information you wish to provide about your child's safety environment.		

### CURRENT CONCERNS

Are there any concerns about your child's health?	Y	N
Are there any concerns about your child's development?	Y	N

THANK YOU.