

## NEW PATIENT INFORMATION SHEET

### AGES 1 TO 18 YEARS

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:		
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?		
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.		

### PATIENT'S MEDICAL HISTORY

Date of child's last medical checkup:	Doctor's Name:	
Date of child's last dental checkup:	Dentist's Name:	
Has child had a reaction to any immunization? If yes, please list each immunization and what the reaction was.	Y	N
Has child been hospitalized for anything since birth? If yes, please explain.	Y	N
Has child had any surgeries or operations? If yes, please explain.	Y	N

Is your child on any medications today? If yes, please list medications and how long child has been on them.	Y	N
Does your child take medication regularly? If yes, please list medications and how long child has been on them.	Y	N
Please add any additional information you wish to provide about child's medical history.		

### PATIENT AND 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/Allergies	Y	N	Y	N	
Diabetes	Y	N	Y	N	
Heart Trouble/Murmur	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 or Abdominal Pain	Y	N	Y	N	
Seizures/Headaches	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.					

### FEEDING AND NUTRITION

Is your child's appetite usually good?	Y	N
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Is it good today? If no, please explain.	Y	N
Was there severe colic or any unusual feeding problem during first 3 months?	Y	N
Do any foods disagree with your child? If yes, please list.	Y	N
For the first 6 months, was your child bottle-fed or breast-fed? If bottle-fed, which formula did you use?	Y	N
Does your child take vitamins? If yes, list the kind of vitamins taken.	Y	N
Please add any additional information you wish to provide about child's feeding or nutrition.		

**DEVELOPMENTAL/BEHAVIORAL**

Are there any concerns about your child's development?	Y	N
How does your child compare to others of his/her own age?		
Does your child have trouble sleeping?	Y	N
Has your child skipped or repeated any grades?	Y	N
Has your child had any trouble in school? If yes, please explain.	Y	N
Please check any of the following that are applicable to your child: <input type="checkbox"/> Nail Biting <input type="checkbox"/> Thumb Sucking <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Bad Temper <input type="checkbox"/> Toilet Training Problems <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Nightmares <input type="checkbox"/> Speech Problems		
Has your child had any problems with discipline? If yes, please explain.	Y	N
Please add any additional information you wish to provide about behavior or development.		

**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
Does your child wear a helmet when riding a bicycle, motor scooter, skateboard, etc.?	Y	N
Please add any additional information you wish to provide about your child's safety environment.		

THANK YOU.