# NEW PATIENT MEDICAL HISTORY

*Pediatric Partners of the Southwest Tel: (970) 375-0100 Fax: (970) 375-9210*

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT

***WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES***

The following is **very important** to your child's health. Please complete it **accurately** and **completely.**

**Childs name:**_____ **Birth date:**_____

Where was your child born?_____ Is child adopted or fostered? Y N

| BIRTH HISTORY | | | |
|---|---|---|---|
| Birth Weight: lbs. oz. Vaginal birth? C-section? | | | |
| Was the baby: (circle one) Full term Early Late | | | |
| If early, how many weeks gestation? | | | |
| Did the baby have any problems right after birth? | | | |
| Did mother have any problems with the pregnancy? | | | |
| | | | |
| DEVELOPMENTAL HISTORY | No | Yes | If yes, explain: |
| Are you concerned about your child's physical development | | | |
| Are you concerned about your child's attention span? | | | |
| How is your child's behavior in school? | | | |
| What kind of grades does he/she make in academic subjects? | | | |
| Is he/she in a special or resource classes? | | | |
| When did your child: Sit up: mos. Crawl: mos. Walk mos. | | | |
| | | | |
| PATIENT ALLERGIES | No | Yes | |
| Any known drug allergies? | | | |
| If you answered yes – Is your child allergic to: | | | |
| Penicillin (Amoxicillin, Augmentin) | | | |
| Cephalosporins (Omnicef, Keflex, Rocephin, Suprax) | | | |
| Sulfa (Septra/Bactrim) | | | |
| Zithromax/erythromycin | | | |
| Other Antibiotics or medications? Give name: | | | Reaction: |
| Peanuts or other nuts – Give name or Group: | | | Reaction: |
| Milk | | | |
| Eggs | | | |
| Seafood | | | |
| Other Foods – give name here: | | | Reaction: |
| Bees / Wasps | | | |
| Indoor Allergens (pets, molds, dust) | | | |
| Outdoor Allergens (trees, weeds, pollens) | | | |
| Latex | | | |
| Other Allergies: | | | Name: |
| PATIENT SOCIAL HISTORY | No | Yes | |
| Does patient live with both mother and father in the same house? | | | |
| Non-intact home – explain custody status | | | Lives with: |
| Does non-custodial parent have visitation rights? | | | |
| Are there siblings? | | | |
| Are there smokers in the home? | | | |
| Are there guns in the home? | | | |
| Are guns locked and kept separate from ammunition? | | | |

| PATIENT – PAST MEDICAL HISTORY | No | Yes | If yes, explain: |
|---|---|---|---|
| Serious accidents or injuries | | | |
| Surgeries | | | |
| Hospitalizations | | | |
| Chicken Pox Disease | | | What age: |
| Frequent ear infections or sinus infections | | | |
| Frequent sore throats or tonsillitis | | | |
| Other infection illnesses | | | |
| Allergic rhinitis or other allergy | | | |
| Asthma, bronchitis, bronchiolitis, pneumonia or croup | | | |
| Heart problems or heart murmur | | | |
| Abdominal pain/reflux | | | |
| Constipation requiring doctor visits | | | |
| Bladder or kidney infection or other urologic problem | | | |
| Bed-wetting (after age 5) | | | |
| Eye conditions / wear corrective lenses | | | |
| Problems with ears or hearing | | | |
| Chronic or recurrent skin problems / acne | | | |
| Anemia or bleeding problem | | | |
| Past blood transfusion | | | |
| Frequent headaches | | | |
| Convulsions, seizures, or past concussions | | | |
| Mental health concerns | | | |
| Seizures, developmental delays, ADD/ADHD or other neurological disorders | | | |
| Orthopedic problems | | | |
| Diabetes | | | |
| Thyroid, diabetes or other endocrine problems | | | |
| If female, have menstrual periods started | | | |
| If female, any problems with periods | | | |
| Use of alcohol or drugs | | | |
| Emotional or mental health problems | | | |
| Other significant issues: | | | |
| | | | |
| Current Medications and Dosage: (include any over the counter, herbal, or supplements) | | | |
| Does your child see any specialists? If so, who and where? | | | |

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition
Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather

| **FAMILY – PAST MEDICAL HISTORY** | **NO** | **YES** | If **YES** – Please check which biological relative | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| *List or explain condition if possible* | | | Mom | Dad | Sib | Maternal Gr Mth | Maternal Gr Fth | Paternal Gr Mth | Paternal Gr Fth |
| Nasal Allergies or other allergies | | | | | | | | | |
| Asthma/lung disease | | | | | | | | | |
| Heart disease or heart condition | | | | | | | | | |
| High blood pressure | | | | | | | | | |
| High cholesterol | | | | | | | | | |
| Diabetes or other endocrine problem | | | | | | | | | |
| Cancer – What type? | | | | | | | | | |
| Anemia | | | | | | | | | |
| Bleeding disorders | | | | | | | | | |
| Epilepsy or convulsions | | | | | | | | | |
| Mental retardation/developmental disorders | | | | | | | | | |
| Neurological disorder including ADHD/ADD | | | | | | | | | |
| Liver disease | | | | | | | | | |
| Other GI disease/disorder | | | | | | | | | |
| Kidney disease | | | | | | | | | |
| Bed-wetting (after age 10) | | | | | | | | | |
| Hearing impairment | | | | | | | | | |
| Vision impairment or eye disorder | | | | | | | | | |
| Immune problems, recurrent infections or HIV-AIDS | | | | | | | | | |
| Alcohol abuse | | | | | | | | | |
| Drug abuse | | | | | | | | | |
| Mental illness | | | | | | | | | |
| Tuberculosis | | | | | | | | | |
| Other issues: | | | | | | | | | |
| | | | | | | | | | |

Is there anything else regarding your child's health that you think we should know that has not already been asked?____

_____

_____

_____

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I attest that all medical history information is true and correct to the best of my knowledge:

Signature:_____ Print Name:_____

Relationship to patient:_____ Date:_____