NEW PATIENT DATABASE

Dear Parent,
We welcome your child or children to our practice. Please fill in as much of this form as you can. This will assist us in getting to know your child and in providing the best possible care.

Child's Name _____ **Birthdate** _____ **Gender** _____

Siblings _____

Person completing form _____ **Relationship** _____ **Date** _____

I. Birth and Past Medical History

A. Pregnancy, Labor, and Birth:

1. Did mother experience any unusual illnesses or complications during pregnancy?
   No____ Yes ____ If yes, please explain:

2. Were there any problems with the delivery?
   No ____ Yes ____ If yes, please explain:

3. Birth weight _____ Mode of delivery _____

4. Did the baby have any trouble directly after birth or during the first week of life?
   No ____ Yes ____ If yes, circle below:

   Blue spells Breathing difficulties Birth defect Drug withdrawal Infection
   Jaundice Required oxygen Seizure Transfusion Vomiting
   Other: _____

B. Illnesses and Health Problems:

1. Has your child had an unusual number of illnesses or other problems requiring medical care?
   No ____ Yes ____ If yes, circle below:

   Excessive colic Feeding problems Ear trouble Frequent/persistent colds Wheezing
   Drug reactions Hoarseness Convulsions Urinary infections Skin problems
   Diarrhea Constipation Vomiting Behavior problems Pneumonia
   Other: _____

2. Does your child have allergies of any kind?
   No ____ Yes ____ If yes, please explain:

3. Has your child ever been hospitalized?
   No ____ Yes ____ If yes, please describe:

4. Has your child had any surgeries?
   No ____ Yes ____ If yes, please describe (include date):

5. Does your child take any medications regularly? _____

NEW PATIENT DATABASE, CONTINUED

II. Developmental History

1. Do you feel that your child's development is normal?
   Yes ____ No ____ If no, please explain:

2. To the best of your knowledge, when did you first notice the following developmental milestones:
   a. Smiling _____ b. Pulling to stand _____ c. Rolling over both ways _____
   d. Sitting _____ e. Walking alone _____ f. Saying words _____
   g. Potty training _____

III. Family Health History

Father's age _____ Mother's age _____ Sibling's ages _____
Health status _____ Health status _____

Do any family members have a history of any of the following health conditions or illnesses?

Allergies ____	Anemia ____	Alcoholism/drug abuse ____	Asthma ____
Birth defects ____	Cancer ____	Blood disorders ____	High cholesterol ____
Cystic fibrosis ____	Diabetes ____	Down syndrome ____	Hearing loss ____
Heart disease ____	Infant death ____	High blood pressure ____	Joint/bone problem ____
Learning problem ____	Mental illness ____	Skin disorders ____	Seizures ____
Stomach problem ____	Tuberculosis ____		

Other: _____

IV. Environmental & Social History

1. Occupations: Father_____ Mother _____
2. Home: Single family dwelling ____ Apartment ____ Other _____

   Family members not living at home _____

   Extended family living at home _____

3. Pets: _____

4. Drinking water source: _____

5. Are the children exposed to smokers? _____

6. Does your child live in or regularly visit a house or other location built before 1960? ____

7. Does your child live with someone whose job or hobby involves exposure to lead? ____

V. Current Information

1. What is the main reason for your child's visit?

   _____
   _____
   _____
   _____

2. Is there anything else you'd like to discuss?

   _____
   _____
   _____
   _____