



PEDIATRIC NEW PATIENT FORM

DATE: ____/____/____

NAME: _____

DOB: ____/____/____

MOTHER'S NAME: _____

AGE: _____

FATHER'S NAME: _____

SIBLING(S)/AGE(S): _____

Special cultural beliefs that might affect child's healthcare _____

HISTORY:

Complications w/pregnancy _____

Birth: vag C-section

Birthweight: _____ Birthlength: _____

Special diet: yes no _____

Medications: _____

Drug/medication allergy: no yes: _____

Surgeries: (Age, Diagnosis): _____

Hospitalizations (Age, Diagnosis): _____

Any problems at school: _____

Other problems: _____

FAMILY HISTORY

- Stroke/heart disease
- Cystic fibrosis
- Sickle cell disease
- Diabetes
- Hip problems
- High blood pressure
- Scoliosis
- Melanoma/skin cancer
- Recurrent ear infections
- SIDS/Early infancy death
- TB
- Kidney disease
- Anemia/bleeding
- Deafness
- Seizures
- Lazy eye
- Allergies/asthma/eczema
- Attention deficit disorder

IMMUNIZATION DATES:

DPT 1	OPV 1	DPT/HIB 1	HIB 1
DPT 2	OPV 2	DPT/HIB 2	HIB 2
DPT 3	OPV 3	DPT/HIB 3	HIB 3
DPT 4	OPV 4	DPT/HIB 4	HIB 4
DPT 5	MMR 1	DT	HEPB 1
	MMR 2	TB	HEPB 2
	Chicken Pox	TB	HEPB 3

DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR CHILD'S HEALTH OR DEVELOPMENT?
