Pediatric New Patient History Form

Erlanger Primary Care

Patient's name: _____
Date of birth: _____
Gender: Male Female

Today's Date: _____
Form completed by: _____
Relationship: _____

Birth History:

Was the baby born term? **Yes** **No**
How many weeks at delivery: _____
Was NICU stay required? **Yes** **No**
(If yes, explain): _____
Delivery: Vaginal Cesarean
(If Cesarean, explain): _____

During pregnancy, was child exposed to:
Tobacco: **Yes** **No**
Alcohol: **Yes** **No**
Drugs/Medication: **Yes** **No**
(If yes to any of above, explain): _____
Was baby breast fed: **Yes** **No**
Any problems during pregnancy?
(Diabetes, high blood pressure, infection)

_____

Has your child ever been hospitalized?
Yes **No**
If yes, explain:

_____

Has your child had any surgeries? **Yes** **No**
If yes, please list what surgery and date of surgery.

_____

_____

Family History:

Do any family members have any of the following conditions? Please circle and specify relationship:

	Relative		Relative
Allergies		High BP	
Anemia		High cholesterol	
Anxiety		Kidney disease	
Asthma		Liver disease	
Behavioral		Lung disease	
Cancer		Sickle Cell	
Depression		Seizures	
Diabetes		Tuberculosis	
Heart disease		Other:	

Does your child attend daycare? **Yes** **No**
Does your child attend school? **Yes** **No**

Do you consider your child to be in good health?
Yes **No**
If no, explain:

_____

Does your child have any chronic medical conditions?
Yes **No**
If yes, explain:

_____

Has your child ever seen a physician for anything other than a wellness checkup?
Yes **No**
If yes, explain:

_____

Is your child allergic to medications or drugs?
Yes **No**
Please list medication and reaction type (hives, rash, etc).

_____

Is your child on any medication?
Yes **No**
If yes, please list medication and dose.

_____

_____

_____

In your opinion, has your child's growth and development been normal? **Yes** **No**
If no, explain:

_____