New Patient Medical History

To be completed by Parent or guardian

Name_____Date of Birth_____

Is your Child allergic to any Medications? Please list_____

_____

Is your Child taking Medication prescription or non prescription on a daily basis? Yes No

Please list Medications_____

_____

_____

_____

Does your Child has any Chronic illness?_____

_____

_____

Has your Child had any Broken Bones?_____

Has your Child had any Stitches?_____

Has your Child had any Hospitalizations or Surgeries? Please List_____

_____

_____

Has your Child had a Blood Transfusion? Yes No

If your Child up to date with Immunizations? Yes No

Has your Child Had Chicken pox illness or Vaccine?_____

(Please provide a copy of your child's immunization record.)

If there a Family History of Heart Disease, Diabetes, High Blood Pressure or Thyroid Disease? Please list relations and Disease._____

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_____

Developmental delay Yes No Speech Delay Yes No

Has your Child been diagnosed with Asthma? Yes No

Please list your child's Birth weight_____ vaginal delivery or C-Section.

Breast or Bottle fed_____ Formula_____

Place of Birth_____ State_____

Complications during Pregnancy_____

Complications at delivery_____

Jaundice_____ Colic_____ Heart Murmur_____Reflux (Frequent vomiting)_____

Sleep Apnea Yes No Chronic Snoring Yes No

Chronic Medical conditions_____

_____

_____

Does your child sleep in his/her own bed? Yes No Ride a bike? Yes No

Wear a helmet while riding a bike? Yes No Wear a seatbelt? Yes No

Does your child have good interaction with the family? Yes No

Does your child sleep: Good Fair Poor Restless Sleep Sound Sleep

Is your child's appetite: Good Fair Poor Picks at food Vegetarian

Number of full meals per day_____ Snacks_____

Does your child drink milk? Yes No

Whole Milk 2% 1% Skim Soy Ounces per day_____

Parent signature Date