Today's date: _____

NEW PATIENT MEDICAL INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Name of person completing this form & relationship to patient: _____

Birth History:
Birth weight: _____Mode of Delivery: Vaginal C-section Complications: _____

Length of Pregnancy: _____ Hospital & City _____

Complications after delivery: _____

Past Hospitalizations/Surgeries:

1. Reason/Diagnosis: _____

   Date of Hospitalization/Surgery: _____

2. Reason/Diagnosis: _____

   Date of Hospitalization/Surgery:_____

Has this child had any of the following? (Please circle YES or NO)

Chicken Pox	Yes	No	(if yes, month/year: ___/___)
Wheezing/Asthma	Yes	No	
Ear Infections	Yes	No	(if yes, approximate number _____)
Urinary Tract Infection	Yes	No	
Seizures/Convulsions	Yes	No	
Anemia	Yes	No	

Please list any other significant medical issues:

_____

_____

_____

Please list any medications the patient is currently taking (include supplements):

_____ _____

_____ _____

Please list any known drug or food allergies and the nature of the reaction (rash, swelling, etc.)

_____

_____

Family History

Please circle YES if the child's parents, grandparents, siblings, aunts, or uncles have had any of the following illnesses and indicate the relationship to the child:

High Cholesterol	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension (high blood pressure)	Yes	No	_____
Cancer	Yes	No	_____
Asthma	Yes	No	_____
Diabetes	Yes	No	_____
Seizure Disorder/Convulsions	Yes	No	_____
Thyroid disease/Lupus/Autoimmune disease	Yes	No	_____
Hearing Loss/Deafness	Yes	No	_____
Kidney Disease	Yes	No	_____
Tuberculosis	Yes	No	_____
Mental Retardation	Yes	No	_____
Other genetic conditions/diseases	Yes	No	_____

Due to genetic pre-disposition to certain diseases, we request your child's ethnic background.
Please check all that apply:

	Father	Mother
African American	☐	☐
Asian/Pacific Islander	☐	☐
Caucasian	☐	☐
Hispanic	☐	☐
Native American	☐	☐

Other, please specify: _____

Other

Do you have a pool at home?	Yes	No
How old is your house? (Relates to risk for lead exposure)	_____	
Does anyone at home smoke?	Yes	No
Do you regularly travel outside of the US?	Yes	No

Any other information you would like the physician to know about your child?

_____

_____

_____

_____

Thank you for taking the time to fill out this form. It will be reviewed by your child's physician and will become part of the medical record.