NEW PATIENT *CHILD* FORM

Patient's Name: _____ Date of birth: _____

CHIEF COMPLAINT:

What is the reason for this appointment? _____

HISTORY OF PRESENT ILLNESS:

Where does it hurt or bother the patient? _____

What kind of pain? None ____ Sharp _____ Dull _____ Constant _____ Intermittent _____

Does anything make it better or worse? _____

Any other associated symptoms? _____

PAST MEDICAL HISTORY:

List any medical conditions that the patient is\has been treated for: _____

_____

List any prior surgeries or hospitalizations: _____

Was the pregnancy with this child normal? _____ If "No" Please describe _____

Did the child go home the same time as mom from the hospital? _____

Birth weight: _____ Is the child exposed to any tobacco smoke? _____

Are Immunizations up to date? _____ If "No" which are missing? _____

List all the Medications that the child is taking 1. _____ 2. _____ 3. _____

List any drug allergies: _____

SOCIAL HISTORY:

Is the child in school? _____ If "Yes" which grade? _____

Is the child in daycare? _____ If "Yes" how often? _____

REVIEW OF SYSTEMS	NO	YES	FAMILY	REVIEW OF SYSTEMS	NO	YES	FAMILY
Anesthesia Complications	☐	☐	☐	High Cholesterol	☐	☐	☐
Arthritis	☐	☐	☐	Kidney Disease	☐	☐	☐
Asthma	☐	☐	☐	Lung Disease	☐	☐	☐
Cancer	☐	☐	☐	Migraines	☐	☐	☐
Diabetes	☐	☐	☐	Muscle Aches	☐	☐	☐
Ear infections	☐	☐	☐	Rash	☐	☐	☐
Easy bleeding\ bruising	☐	☐	☐	Seizures	☐	☐	☐
Fevers	☐	☐	☐	Snoring	☐	☐	☐
Hearing loss	☐	☐	☐	Stomach Problems	☐	☐	☐
Heart Disease	☐	☐	☐	Unexplained weight loss	☐	☐	☐
Heart Burn\ Reflux	☐	☐	☐	Visual symptoms	☐	☐	☐
High Blood Pressure	☐	☐	☐	Wheezing	☐	☐	☐

Other: _____

Are there any "free bleeders" in your family? _____ If "Yes" Who in the family _____