

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 day care? _____ If "Yes" how often? _____

<u>REVIEW OF SYSTEMS</u>	<u>NO</u>	<u>YES</u>	<u>FAMILY</u>	<u>REVIEW OF SYSTEMS</u>	<u>NO</u>	<u>YES</u>	<u>FAMILY</u>
Anesthesia Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding\ bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Burn\ Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visual symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____							

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