



NEW PATIENT HISTORY

NAME: _____ DATE: _____ MRN#: _____

Accompanied by: Mother Father Grandparent Other _____

Chief complaint: well child exam sick with: _____

Current habits:

Bowels: Brown Yellow Hard Soft Watery Daily With each feed 2-3 times/day

Every other day Feeding: Regular meals Picky eater Formula Breast _____ OZ every _____ hrs. brand _____

Sleeping: Sleeps through the night Wakes at night Bedtime _____pm Vision: No difficulty Decreased vision

Hearing: No difficulty Decreased hearing Dentist: Regular care Never As needed

Past medical history:

Newborn history: Full term Premature _____wks

- Mom's blood type A B AB O Rh+ Rh-
- Mom was +/- for Hepatitis B +/- GBS +/- Chlamydia +/- HIV +/- Rubella +/- PPD +/-
- Vaginal delivery Cesarean section
- Prenatal complications _____
- Neonatal complications: Jaundice Sepsis low sugar antibiotics feeding problem
- Hearing screen Pass Fail

Medical diagnosis: _____

Surgeries: _____

Allergies: _____

Medications: _____

Family History:

	Diabetes	High Blood Pressure	High Cholesterol	Heart murmur	Kidney Failure	Cancer	Arthritis
Mom							
Dad							
Other							

Social History:

Day care: None Licensed Relative Home w/sitter Private home

Smoking: Smokers in home Smokes Cigarettes Pot

Pets in Home: Dog Cat Bird Fish _____ Other

Parents work: At home Outside home Jail

Mom			
Dad			