New Pediatric Patient Medical History

Patient's Name – _____

Date of Birth_____ Current Age - _____

Primary Contact - _____

Relationship - _____ Email address - _____

Home Phone - _____ Work / Cell Phone - _____

Address - _____

Secondary Contact - _____

Relationship - _____ Email address - _____

Home Phone - _____ Work / Cell Phone - _____

Address - _____

Please list all health care providers and their complete addresses that your child sees –

_____

_____

_____

_____

_____

What is the reason you are here today? _____

_____

Is this your first child? _____ If not, how many children do you have?_____

Please list any medical problems that your child has - _____

_____

_____

Please list all operations your child has had, and where they were performed - _____

_____

_____

Please list all medications and dosages - _____

_____

_____

Please list any food or drug allergies your child has - _____

_____

Anything else you wish to tell Dr. Rhodes? _____

_____

Signature_____ Date - _____

If your child is under 5 years old, please complete the following pregnancy questionnaire:

How long was the pregnancy (in weeks)? _____

Did you/the mother smoke during pregnancy?_____

Were there any problems during the pregnancy? Please explain.

_____

_____

Did you/the mother take any medications or drugs during preganancy?

_____

_____

If delivery was by c-section, please state why a c-section was perfomed?

_____

Which hospital did you /the mother have the baby at?_____

What was your child's birth weight?_____

What is your child's weight now?_____

Signature_____ Date - _____