Rose City Pediatrics Medical Group

**Confidential**

New Patient Information

*Please take a moment to complete the following information*.

## Birth history

What did your child **weigh** when s/he was born? . . . . . ____lb ___oz
Was your child born **early or late**? . . . . . ____yes ___no
If yes, how may **weeks early**? . . . . . _____ weeks
If late, how many **weeks late**? . . . . . _____ weeks
Was your child born **vaginally?** . . . . . ____yes ___no
Was your child born via **cesarian section**? . . . . . ____yes ___no
If born by cesarean section, this was done **because** of (check all that apply)
__prematurity
__prolonged labor
__baby's head was too big
__problems with the baby's heart rate
__maternal infection
__prior history of cesarean section in mother
How old was the mother when this child was born? . . . . . _____ years
How many times had the mother been **pregnant**, including the pregnancy with this child? . . . Gravida: _____
How many times has the mother **delivered** an infant, including this child? . . . . . Para: _____
Did the mother have **prenatal care** throughout the entire pregnancy with this child? . . . . . ____yes ___no
Did the mother take any **medication**s other than prenatal vitamins during the pregnancy? . . . . . ____yes ___no
Did the mother have any **illnesses** during the pregnancy? . . . . . ____yes ___no
How many days were the mother and infant in the hospital? . . . . . _____ days

## Past medical history

Does your child have any **medical conditions** or diagnosis at this time? . . . . . ____yes ___no
Does your child have any **allergies?** . . . . . ____yes ___no
**Has your child previously been prescribed pain killers or other controlled substances?** . . ____yes ___no
If so, what is s/he allergic to? **ALLERGIC TO**: _____
If so, what happens if your child is exposed to this substance?

__rash __facial swelling __difficulty breathing __other

Has your child **ever** been **hospitalized**? . . . . . ____yes ___no
If so, what was the hospitalization for? **HOSPITALIZED FOR**:_____
Has your child ever been treated in an **emergency room**? . . . . . ____yes ___no
If yes, what was s/he treated for? **EMERGENCY TREATMENT FOR**:_____
Has your child ever had a blood **transfusion**? . . . . . ____yes ___no
Has your child ever had a **fracture**? . . . . . ____yes ___no
If yes, which bones were involved? **FRACTURE SITES**:_____
If yes, how old was your child when the fracture occurred? . . . . . **AGE**: _____
Is your child taking any **medications** at this time? . . . . . ____yes ___no
If yes, what medications are being taken? **MEDS**:_____

## Preanestehetic Evaluation

**The following information is useful in the event your child requires surgery.**

Has your child ever had **surgery**? ____yes ___no

If so, what was done? **PRIOR PROCEDURES/DATES**_____/_____

If your child is male, is he circumcised? ____yes ___no
Does your child have a **history of recurrent croup**? ____yes ___no
Does your child have a **history of asthma or wheezing** with respiratory infections? ____yes ___no
Is there a history of **breathing irregularities** of any type? ____yes ___no
Has your child experienced an **abnormal weight loss**? ____yes ___no
Does your child **fatigue** substantially more **easily** than other children his/her age? ____yes ___no
Does your child have a **history of prolonged bleeding**? ____yes ___no
Has your child **taken steroid medications** within the last six months? ____yes ___no
Has your child ever had an **adverse reaction** to anesthetic agents? ____yes ___no
Is there a **family history** of reactions to anesthesia?. ____yes ___no
Does your child have a significant **history of medical procedures**, such as blood draws? ____yes ___no

## Developmental history (complete as appropriate)

How old was your child when s/he
Started sitting unassisted?. _____months
Started **walking**? _____months
Said his/her **first word**? _____months
Said his/her **first sentence**? _____months
Was **toilet trained**? _____months
Is your child **in daycare**? ____yes ___no.
Does your child **go to school**? ____yes ___no
If yes, is **school performance** at or above grade level? ____yes ___no
Has **anyone** ever expressed **concern over** your child's **academic performance**? ____yes ___no
Has **anyone** ever expressed **concern over** any of your child's **social behaviors**? ____yes ___no
Do **you** have any concerns about your child's academic performance? ____yes ___no
Do **you** have any concerns about your child's abilities to relate to others? ____yes ___no
Does your child take part in any **extracurricular** activities? ____yes ___no

## Review of systems / Family history

Please list all **siblings**

| Name | gender | age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please indicate if there is a history of any of the conditions listed below in either your child or in any of the relatives shown by placing a check in the appropriate column.

| **Medical Condition** | **Relation to patient** | | | | | |
|---|---|---|---|---|---|---|
| | **Patient** | **sibling** | **parent** | **grandparent** | **aunt or uncle** | **cousin** |
| Anorexia or bulimia | _____ | _____ | _____ | _____ | _____ | _____ |
| Autism | _____ | _____ | _____ | _____ | _____ | _____ |
| Attention deficit disorder | _____ | _____ | _____ | _____ | _____ | _____ |
| Learning disorder | _____ | _____ | _____ | _____ | _____ | _____ |
| Seizures or epilepsy | _____ | _____ | _____ | _____ | _____ | _____ |
| Migraine headache | _____ | _____ | _____ | _____ | _____ | _____ |
| Other neurologic condition | _____ | _____ | _____ | _____ | _____ | _____ |
| Nearsightedness | _____ | _____ | _____ | _____ | _____ | _____ |
| Strabismus (‘lazy/cross eye’). | _____ | _____ | _____ | _____ | _____ | _____ |
| Other ocular problems | _____ | _____ | _____ | _____ | _____ | _____ |
| Alcoholism | _____ | _____ | _____ | _____ | _____ | _____ |
| other substance abuse | _____ | _____ | _____ | _____ | _____ | _____ |
| Anxiety or Depression | _____ | _____ | _____ | _____ | _____ | _____ |
| Other psychiatric condition | _____ | _____ | _____ | _____ | _____ | _____ |
| High blood pressure | _____ | _____ | _____ | _____ | _____ | _____ |
| Irregular heart beat | _____ | _____ | _____ | _____ | _____ | _____ |
| Heart murmur | _____ | _____ | _____ | _____ | _____ | _____ |
| Other congenital heart disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Aneurysm | _____ | _____ | _____ | _____ | _____ | _____ |
| Other heart conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ | _____ | _____ | _____ |
| Cystic fibrosis | _____ | _____ | _____ | _____ | _____ | _____ |
| Other respiratory conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Diabetes in childhood | _____ | _____ | _____ | _____ | _____ | _____ |
| Thyroid problems | _____ | _____ | _____ | _____ | _____ | _____ |
| Onset of puberty after age 13 | _____ | _____ | _____ | _____ | _____ | _____ |
| Onset of puberty before age 8 | _____ | _____ | _____ | _____ | _____ | _____ |
| Short stature | _____ | _____ | _____ | _____ | _____ | _____ |
| Delayed growth | _____ | _____ | _____ | _____ | _____ | _____ |
| Obesity | _____ | _____ | _____ | _____ | _____ | _____ |
| Other endocrine conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Down’s syndrome | _____ | _____ | _____ | _____ | _____ | _____ |
| Other syndromes | _____ | _____ | _____ | _____ | _____ | _____ |
| Inherited forms of anemia | _____ | _____ | _____ | _____ | _____ | _____ |
| Irritable bowel syndrome | _____ | _____ | _____ | _____ | _____ | _____ |
| Celiac disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Food allergies | _____ | _____ | _____ | _____ | _____ | _____ |
| Crohn’s disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Ulcerative colitis | _____ | _____ | _____ | _____ | _____ | _____ |
| Other intestinal conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Kidney stones | _____ | _____ | _____ | _____ | _____ | _____ |
| Other kidney conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Scoliosis | _____ | _____ | _____ | _____ | _____ | _____ |
| Other inherited bone conditions | _____ | _____ | _____ | _____ | _____ | _____ |
| Systemic Lupus | _____ | _____ | _____ | _____ | _____ | _____ |

| **Medical Condition** | **Patient** | **sibling** | **parent** | **grandparent** | **aunt or uncle** | **cousin** |
|---|---|---|---|---|---|---|
| Juvenile Rheumatoid Arthritis | _____ | _____ | _____ | _____ | _____ | _____ |
| Hernia/other urologic condition | _____ | _____ | _____ | _____ | _____ | _____ |
| Childhood cancer or leukemia | _____ | _____ | _____ | _____ | _____ | _____ |
| Skin problems of significance | _____ | _____ | _____ | _____ | _____ | _____ |
| Tuberculosis | _____ | _____ | _____ | _____ | _____ | _____ |
| Hepatitis (any form) | _____ | _____ | _____ | _____ | _____ | _____ |

## Social history

Parents are __married __separated __divorced __widowed

Parents' **occupations:** _____ _____

**Religious affiliation**, if any: _____

Do you have any **pets** at home? ____yes ___no
Do you have a **pool?** ____yes ___no
Are there any **smokers** at home? ____yes ___no
Are there any **guns** at home? ____yes ___no
Which **languages** are **spoken** at home? ___English ___other:_____

Do you have any **specific concerns** about your child today? ____yes ___no

Whom may we thank for **referring** you to us? _____

**Physician notes**:

Reviewed: _____MD

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