Child's Name ______________________________ ☐ male ☐ female ***Birthdate***_________________ *Acct#*________

NEW PATIENT INFORMATION and HISTORY

Parent #1 Name________________________________ ☐male ☐female **Occupation**______________________________

Parent #2 Name________________________________ ☐male ☐female **Occupation**______________________________

Please check one in each column:

	Child Care	Primary Caretaker
☐ Parents married and together	☐ Home with Parent(s)	☐ Mother
☐ Parents unmarried and together	☐ Day Care Center	☐ Father
☐ Single Parent	☐ Baby sitter in Home	☐ Grandparent
☐ Parents divorced	☐ Family Day Care	☐ Other (specify)
☐ One Parent deceased	☐ Other_____________	_______________

Who has **legal** custody/authority to consent to your child's medical care and vaccines?______________________________

Please Circle Answer:

Smokers in home: No Yes Specify who ________________________________

Parent /child interaction concerns: No Yes____________________________________

Newborn History: Full term Yes or Premature (age in weeks at birth)___________

Delivery: C-section, Vaginal, Forceps, Vacuum Birth weight___________________

Any problems at birth or the first week of life? No Yes ____

Development: Any concerns or problems, No Yes (specify)____

Any history of speech, occupational, or physical therapy? No Yes (specify)_____________________________________

Any psychiatric or emotional problems requiring evaluation or treatment? No Yes (why)____________________________

Any Chronic Medical Problems: Diagnosis/Diagnoses____

____

Ongoing Treatment____

Surgical History: Type of surgery/Date ____

____

Overnight Hospitalizations: Reason/Date____

____

Major Injury or Trauma: Type of Injury/Date____

History of Chicken Pox?: No Yes (when)_____________

Other Remarkable childhood diseases: Diagnosis/ Date____

__________________________________Date_____________ ____________________________Date__________

Signature and Relationship to Child ***Doctor Signature***

rev 12/15/10