NEW PATIENT INFORMATION (Children 0-12)

Name:_____ DOB:_____/_____/_____ Date:_____/_____/_____
Person providing information:_____

1. Medication

List any Medications you cannot take and why:_____
List the medicines you are currently taking:

Medication (name / dose)	Medication (name / dose)	Medication (name / dose)

2. Illnesses:

Check if you have or have had any of the following illness:

	Rheumatic Fever		Pneumonia		Cancer		Tuberculosis
	Heart Trouble		Emphysema		Menstrual Problems		Glaucoma
	High Blood Pressure		Ulcers		Stroke		Colitis
	Asthma		Hepatitis		Epilepsy / Convulsions		Blood Clots
	Hay Fever		Urinary Tract Problems		Nervous or Mental Illness		Sexual Problems
	Diabetes		Venereal Disease		Skin Problems		Thyroid Problems
	Anemia		Arthritis		Other (specify)		

3. Surgeries / Hospitalizations / Injuries:

List any surgeries, Injuries or operations:

Surgery, Injury, or Reason for hospitalization	Year or Age	Hospital	Doctor's Name

4. Family Medical History

Check if any of these diseases have occurred in blood relatives. List those who have had it.

	Diabetes			Epilepsy			Mental Illness	
	High Blood Pressure			Arthritis			Cancer (type?)	
	Anemia			Allergy				
	Bleeding Disorder			Asthma			Heart Trouble	
	Thyroid Disease			Stroke			Other (list)	
	Tuberculosis			Suicide				

Please list any relatives who have died and the cause of death:

Relative	Cause of Death	Age at Death

5. Birth and Infant History:

List any problems during pregnancy:_____
List any problems during birth:_____
Birth weight:_____ number of days until baby went home home from hospital:_____
Premature?_____ If yes, by how much?_____-
Jaundice at birth?_____
Breast feed?_____ If yes, to what age?_____ Bottle Fed?_____ If yes, name of formula:_____

6. Personal History

List those who are living at home with you (spouse, children, parent, ect):_____
Current school grade?_____ Hobbies:_____

Legal Guardian Signature:_____ Date:_____