New Patient Information

Name: ______________________ **Date of Birth:** ______________ **Today's Date:** ______________

BIRTH HISTORY

How many weeks gestation? ______________ Birth weight: ______________ Type of delivery: ☐ vaginal ☐ C-section

Prenatal / Newborn complications? ______________________________

Infant blood type: ________ or unknown Hearing screen: ☐ pass ☐ fail For males: circumcision performed? ☐ Yes ☐ No

For patients under 2 years of age: Was the infant breech during pregnancy? ☐ *Yes* ☐ *No* ☐ *Unsure*

CHILD'S HISTORY

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Unsure Explain ______________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ Unsure Explain ______________

Has your child had any surgeries? ☐ Yes ☐ No Explain ______________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______________

Is your child allergic to any medications? ☐ Yes ☐ No Explain ______________

Please list your child's medications: ______________________________

FAMILY HISTORY

Have any family members (parents, grandparents, siblings, aunts and uncles of your child) had the following?

If family history is unknown, check here ☐

Condition	Response	Who	Comments
Childhood hearing loss	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Nasal allergies	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Food allergies	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Eczema	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Asthma	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Heart disease (before 55 years old)	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
High cholesterol	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Hypertension	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Diabetes (before 55 years old)	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Anemia	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Bleeding / clotting disorder	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Dental decay	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Cancer (before 55 years old)	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
ADHD / learning disorders	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Autism / developmental disorders	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Liver disease	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Kidney disease	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Seizures	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Substance abuse	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Mental illness / depression / anxiety	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Immune problems, HIV or AIDS	☐ Yes ☐ No ☐ Unsure	Who ________	Comments ________
Additional family history		Who ________	Comments ________

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