

NEW PATIENT INFORMATION (Children 0-12)

Name: _____ 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:

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Stroke	<input type="checkbox"/> Colitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Epilepsy / Convulsions	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Urinary Tract Problems	<input type="checkbox"/> Nervous or Mental Illness	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> 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.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer (type?)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other (list)
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> 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 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: _____