WELCOME TO OUR OFFICE

NEW PATIENT HEALTH INFORMATION

(*please complete this form prior to your visit with our doctors*)

DATE: ______________________

1. Patient's Name:
2. Hospital / Place of Birth:
3. Mother's year of birth: _____ Father's year of birth _____
4. Age and Sex of Patient's Siblings:
5. Do you smoke? Mother (Y) (N) Father (Y) (N)
6. Family history of illness (*please indicate which family member(s)*:
   - ❑ Asthma / Hayfever / Allergy:
   - ❑ Diabetes:
   - ❑ Epilepsy (Seizures) and/or Neurologic Disorder:
   - ❑ High Blood Pressure:
   - ❑ Coronary Artery Disease (*55 years and under*)/Strokes:
   - ❑ Elevated Cholesterol:
   - ❑ Thyroid Disease:
   - ❑ Kidney Disease:
   - ❑ Blood Disorders:
   - ❑ Others:
7. Duration of pregnancy: Full term _____ Premature _____
8. Type of delivery: Vaginal _____ Caesarian Section _____
9. Birth weight: _____ Birth length: _____
10. Child's blood type (*if known*): A ___ B ___ AB ___ O ___; Rh:pos ___ / neg ___
11. Apgar Score (*if known*):
12. Problems in the newborn period (*jaundice, respiratory distress, sepsis*):
13. Did you breast (B) or formula (F) feed this child? B ___ F ___

13a. If you breast fed – how long did you breast-feed this child? _____________

14. Has this child had any surgeries and/or hospitalizations? Y ___ N ___
    (*if so, what type surgery and/or hospitalization and when*):

14a. Does this child have any chronic (recurrent) illnesses? Y ___ N ___
(*if so, what type of illness*):

15. Does this child have any known food and/or drug allergies? Y ___ N ___
(*if yes, to what -* ***describe reaction***)

16. Does this child regularly take any medications? Y ___ N ___
(*if so, please list medication and dosage*)

17. Please include any other health information about your child that you think will be helpful to us in providing proper care.

THANK YOU FOR COMPLETING THIS INFORMATION