

NEW PEDIATRIC PATIENT – 5 YEARS TO 10 YEARS



Name: _____

Birth Date: _____ Sex: M F

Today's Date: _____

Please tell us the **REASON FOR TODAY'S VISIT**: _____

Please list **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea, swelling)

Are **IMMUNIZATIONS** up to date? Yes No **Please provide a copy of immunization record.**

BIRTH HISTORY:

Mother's age at child's birth: _____	Type of Delivery: _____ Vaginal _____ C-Section
Number of pregnancies: _____	Term: _____ Full Term _____ Premature
Was prenatal care given: Yes No	Birth Weight: _____ lbs _____ oz
Any problems after delivery or newborn nursery care? Yes No	Birth Length: _____ inches

DEVELOPMENTAL HISTORY - Please complete for children age 5 ONLY:

Does/Can your child?	Yes	No
Counts 5 objects		
Counts to 10		
Draws people with 2-5 parts		
Follows directions		
Knows address/phone numbers		
Knows on/off, and over/under		
Plays cooperatively		

Does/Can your child?	Yes	No
Pretend play		
Prints name		
Rides bike with training wheels		
Skips		
Speaks understandably		
Tells imaginary stories		

For Nurse Use Only: Height _____ Weight _____ Temp _____ BP _____ Pulse _____ Resp _____

Please provide your **PAST MEDICAL HISTORY**:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Fracture | <input type="checkbox"/> Prematurity |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> GERD(reflux) | <input type="checkbox"/> Pyleonephritis |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Recurrent otitis media |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Concussion, CHI | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures – febrile |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Vesicoureteral reflux |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia | |

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if known**:

- | | |
|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Adenoidectomy |
| <input type="checkbox"/> Inguinal Hernia Repair | <input type="checkbox"/> PET placement |
| <input type="checkbox"/> Fracture with Surgical Reduction | <input type="checkbox"/> Lymph node biopsy/excision |
| <input type="checkbox"/> Dental Surgery | <input type="checkbox"/> Umbilical Hernia Repair |
| <input type="checkbox"/> Tonsillectomy | |

Please list any **ADDITIONAL PAST MEDICAL HISTORY** or **PAST SURGICAL HISTORY** and date/year if known:

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer, Type					
Coronary artery disease (heart disease)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Genetic disorder					
Hemoglobinopathy					

	Mother	Father	Sister	Brother	Other
High cholesterol					
High blood pressure					
Hip Dysplasia					
Learning disability					
Mental retardation					
Migraines DDH					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide your **SOCIAL HISTORY**:

Who lives with your child? _____

Tobacco Exposure	Yes	No
Are there smokers in the house?		
If yes, do they smoke outside only?		
Home Environment	Yes	No
What is the age of the home?		
Is the water chlorinated?		
Is the water fluoridated?		
Is there lead in the home?		
Education	Yes	No
School Name:		
School Grade:		
Does child have any learning disabilities?		
Does child have any special needs?		

Safety	Yes	No
Does your child use a bike/skate helmet?		
Does your child use seat belt in car?		
Do you use a booster seat in car?		
Are smoke detectors in the home?		
Is there a carbon monoxide detector?		
Are there firearms in the home?		
Are there pets in the home?		
If yes, what kind(s)?		