

# Pediatric New Patient History Form

Erlanger Primary Care

Patient's name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Gender:        Male                Female

Today's Date: \_\_\_\_\_  
 Form completed by: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

**Birth History:**

Was the baby born term?        **Yes**    **No**  
 How many weeks at delivery: \_\_\_\_\_  
 Was NICU stay required?        **Yes**    **No**  
 (If yes, explain): \_\_\_\_\_  
 Delivery:                                Vaginal    Cesarean  
 (If Cesarean, explain): \_\_\_\_\_

Does your child attend daycare?        **Yes**    **No**  
 Does your child attend school?        **Yes**    **No**

Do you consider your child to be in good health?  
**Yes**    **No**  
 If no, explain:  
 \_\_\_\_\_

During pregnancy, was child exposed to:  
 Tobacco:                                **Yes**    **No**  
 Alcohol:                                 **Yes**    **No**  
 Drugs/Medication:                **Yes**    **No**  
 (If yes to any of above, explain): \_\_\_\_\_  
 Was baby breast fed:                **Yes**    **No**  
 Any problems during pregnancy?  
 (Diabetes, high blood pressure, infection)  
 \_\_\_\_\_

Does your child have any chronic medical conditions?  
**Yes**    **No**  
 If yes, explain:  
 \_\_\_\_\_

Has your child ever been hospitalized?  
**Yes**    **No**  
 If yes, explain:  
 \_\_\_\_\_

Has your child ever seen a physician for anything other than a wellness checkup?  
**Yes**    **No**  
 If yes, explain:  
 \_\_\_\_\_

Has your child had any surgeries?        **Yes**    **No**  
 If yes, please list what surgery and date of surgery.  
 \_\_\_\_\_  
 \_\_\_\_\_

Is your child allergic to medications or drugs?  
**Yes**    **No**  
 Please list medication and reaction type (hives, rash, etc).  
 \_\_\_\_\_

**Family History:**

Do any family members have any of the following conditions? Please circle and specify relationship:

	Relative		Relative
Allergies		High BP	
Anemia		High cholesterol	
Anxiety		Kidney disease	
Asthma		Liver disease	
Behavioral		Lung disease	
Cancer		Sickle Cell	
Depression		Seizures	
Diabetes		Tuberculosis	
Heart disease		Other:	

Is your child on any medication?  
**Yes**    **No**  
 If yes, please list medication and dose.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In your opinion, has your child's growth and development been normal?  
**Yes**    **No**  
 If no, explain:  
 \_\_\_\_\_