



Goodlettsville Pediatrics, P.C.

New Patient History

Patient Name: _____

Birth Date : _____/_____/_____

Date Form Completed: _____/_____/_____

Birth History

Birth Weight ____# ____oz Hospital / Location _____

Was the baby born: ____ on time OR ____ week(s) early OR ____ week(s) late

Was the delivery: ____ vaginal ____ caesarian If caesarian, why? _____

List any problems during pregnancy or after birth: _____

During pregnancy, did mother:

Smoke? YES NO

Drink Alcohol? YES NO

Use drugs or medications? YES NO

Was the initial feeding: ____ breast ____ bottle

Did the baby go home with mom from the hospital? YES NO

If not, why? _____

Past Medical History

Is your child in good health? YES NO Explain _____

Has your child had a serious illness? YES NO Explain _____

Has your child been hospitalized? YES NO Explain _____

Has your child had any surgery? YES NO Explain _____

Are there allergies to medications? YES NO Explain _____

Please list any long-term medications and vitamin / supplements: _____

Has your child ever had:

Chicken Pox YES NO When? _____

Frequent Ear Infections YES NO Were ear tubes placed? YES NO

Hearing or Vision Problems YES NO Explain _____

Seasonal Allergies YES NO Explain _____

Asthma or Bronchitis YES NO Explain _____

Heart Problems, Murmur YES NO Explain _____

Anemia, Bleeding Disorder YES NO Explain _____

Blood Transfusion YES NO Explain _____

Frequent Headaches YES NO Explain _____

Frequent Abdominal Pain YES NO Explain _____

Constipation requiring doctor visit YES NO Explain _____

Bladder or Kidney infection YES NO Explain _____

Bedwetting after age 5 YES NO Explain _____

Chronic Skin Problems (eczema) YES NO Explain _____

Seizure or Neurologic Problem YES NO Explain _____

Diabetes YES NO Explain _____

Thyroid or Endocrine Problem YES NO Explain _____

Used alcohol or drugs YES NO Explain _____

Behavioral Problems or ADHD YES NO Explain _____

For preteen & teen girls only:

Has she started periods? YES NO When? _____

Are there problems with periods? YES NO Explain _____

Development and School Progress

- Are you concerned about your child's physical development? YES NO
- Are you concerned about your child's emotional development? YES NO
- Are you concerned about your child's behavior? YES NO

Please explain any "yes" answers: _____

For school age children:

- Has your child failed or repeated a grade in school? YES NO Explain: _____
- Is your child receiving any help in school? YES NO Explain: _____
- Are you concerned about behavior at school? YES NO Explain: _____

Family History

Has anyone in the family had the following:

- | | | | | |
|------------------------------|------------------------------|-----------------------------|------------|-----------------|
| Deafness | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Seasonal Allergies | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Asthma | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Tuberculosis | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Heart Attack < 50 years old | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Stroke < 50 years old | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| High Blood Pressure | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| High Cholesterol | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Anemia | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Bleeding Disorder | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Liver Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Kidney Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Diabetes | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Bed Wetting > 10 years old | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Seizures or Seizure Disorder | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Drug or Alcohol Use | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Mental Illness | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Mental Retardation | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |
| Immune Problems, HIV | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Who? _____ | Comments: _____ |

Please List or Describe any Additional Family History: _____

Household and Social History

Please list people living in the child's home:

Name	Relationship to Child	Birth Date	Any health problems?

Are there any siblings not listed? YES NO If yes, list ages and where they live: _____

If parents are separated or divorced, what is the child's custody status? _____

If one or both parents are not living at home, how often does the child see them? _____

Have there ever been any concerns of physical, emotional or sexual abuse of this child? _____

Parent / Guardian Signature _____ Date _____

Provider Signature _____ Date _____