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 _____cesarian If cesarian, 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_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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