NEW PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Person completing form: _____ Relationship to patient:_____

SECTION I - BIRTH HISTORY (Complete Section I only if your child is under 3 years of age):

Birth Weight: _____ Mode of delivery: Vaginal/C-Section Complications: _____

Length of Pregnancy (# of weeks): _____Hospital:_____

Complications during pregnancy or after delivery:_____

SECTION II - PAST HOSPITALIZATIONS, SERIOUS ACCIDENTS, OR SURGERIES:

1. Reason/Diagnosis:_____
   Date: _____
2. Reason/Diagnosis:_____
   Date: _____

Has this patient had: (*Please circle Yes or No*)

Chicken Pox	Yes/No (if yes, please give mo/yr_____)
Wheezing/Asthma	Yes/No
Urinary Tracy Infection	Yes/No
Seizures/Convulsions	Yes/No
Anemia	Yes/No
Lead Poisoning	Yes/No

Any other serious illnesses: _____
_____

Medication/s patient is currently taking: _____
_____

Please list any known medication, food, insect or other allergies and the nature of the reaction (rash/swelling, etc.)_____

SECTION III - FAMILY HISTORY:

Please circle yes if the child's parents, grandparents, siblings, aunts, or uncles have had the following illnesses and indicate the relationship to the child

		Detailed Info (who? Such as-parental GM, maternal aunt)
Asthma	Yes/No	_____
ADHD or Learning disabilities	Yes/No	_____
Cancer	Yes/No	_____
Diabetes	Yes/No	_____
Heart Disease/Heart Attack before age 50	Yes/No	_____
High cholesterol	Yes/No	_____
Lupus/Autoimmine disease	Yes/No	_____
Mental Illness/anxiety/depression	Yes/No	_____
Seizure disorder/convulsions	Yes/No	_____
Sudden or unexplained death before age 50	Yes/No	_____
Thyroid disease	Yes/No	_____