

PEDIATRIC NEW PATIENT INFORMATION BASE

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PEDIATRICIAN: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Any prior treatment? (physical therapy, surgery, braces, etc.): \_\_\_\_\_

Birth History: How many weeks was the pregnancy: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Any problems during pregnancy, labor, delivery? \_\_\_\_\_

Was delivery vaginal or by C-section? \_\_\_\_\_

Was child born head first or feet first? \_\_\_\_\_

Please indicate approximate age at which child first accomplished the goals below:

Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_

Medical Problems: Asthma: \_\_\_\_\_ Seizures: \_\_\_\_\_ Heart Problems: \_\_\_\_\_

Please list any other medical problems: \_\_\_\_\_

Does the child take any medications? (If yes, please list with dosage) \_\_\_\_\_

Does the child have any allergies to medications? (If yes, please list) \_\_\_\_\_

Has your child had any operations? (If yes, please list) \_\_\_\_\_

Are there any illnesses in the family? (If yes, please list) \_\_\_\_\_

.....  
\_\_\_\_\_  
PARENT'S SIGNATURE

SCHOOL: \_\_\_\_\_ SPORTS/ACTIVITIES/INTERESTS: \_\_\_\_\_

GRADE: \_\_\_\_\_