WEISS PEDIATRIC CARE

NEW PATIENT MEDICAL HISTORY
6 Months & Older

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: _____ Birth date: ___/__/_____
Where was your child born? _____ Is child adopted or fostered? Y__ N__
Has your child *ever* previously been seen *in this practice*? Y__ N__

BIRTH HISTORY
Birth Weight: lbs. oz. Vaginal birth? C-section?
Was the baby: (circle one) Full term Early Late
If early, how many weeks gestation?
Did the baby have any problems right after birth?
Did mother have any problems with the pregnancy?

PATIENT ALLERGIES	**No**	**Yes**	If No - explain
This child does not have any known Drug Allergies			
If you answered No - Is your child allergic to:			
Penicillin (Amoxicillin, Augmentin)			
Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax)			
Sulpha (Septra/Bactrim)			
Zithromax/erythromycin			
Other Antibiotics or medications? Give name:			Reaction:
Peanuts or other nuts – Give name or Group:			Reaction:
Milk			
Eggs			
Seafood			
Other Foods – give name here:			Reaction:
Bees / Wasps			
Indoor Allergens (pets, molds, dust)			
Outdoor Allergens (trees, weeds, pollens)			
Latex			
Other Allergies:			Name:
PATIENT SOCIAL HISTORY	**No**	**Yes**	
Does patient live with both mother and father in same house?			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			

PATIENT - PAST MEDICAL HISTORY	No	Yes	If Yes – explain
Serious accidents or injuries			
Surgeries			
Hospitalizations			
Chicken Pox Disease			What age:
Frequent ear infections or sinus infections			
Frequent sore throats or tonsillitis			
Other infection illnesses			
Allergic rhinitis or other allergy			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Abdominal pain/reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other urologic problem			
Bed-wetting (after age 5)			
Eye conditions / wear corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems/ acne			
Anemia or bleeding problem			
Past blood transfusion			
Frequent headaches			
Convulsions, seizures, or past concussions?			
Mental health concerns			
Seizures, developmental delays, ADD/ADHD or other neurological disorders			
Orthopedic problems			
Diabetes			
Thyroid, diabetes or other endocrine problems			
If female, have menstrual periods started?			
If female, any problems with periods?			
Use of alcohol or drugs			
Emotional or mental health problems			
Other significant issues:			

Current Medications and Dosage: (include any over the counter, herbal, or supplements)

_____ _____

_____ _____

_____ _____

Does your child see any specialists? If so, who and where?

_____

_____

Child's name: _____ Birth date: ___/___/_____

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	**NO**	**YES**	If **YES** - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Developmental Disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

Is there anything else regarding your child's health that you think we should know that has not already been asked?

_____

_____

I attest that all the medical history information is true and correct to the best of my knowledge:

_____ _____ ____ /____/____

Signature **Relationship to patient** **Date**

_____ _____ ____ /____/____

Print Name **Child's name** **Birth date**