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.): ______________________________

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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) ______________________________

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

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

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

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PARENT'S SIGNATURE

SCHOOL: ______________________ SPORTS/ACTIVITIES/INTERESTS: ______________________________

GRADE: ______________________