NEW PATIENT RECORD

DATE: _____

Patient Name: _____ DOB: _____ DR.: _____

Birth History:

Hospital: _____ Complications/Toxic Exposures: _____

□ Breast □ Bottle □ Both Under lights? Y N _____

Delivery: TERM / PREMATURE _____weeks □ Vaginal Delivery □ Cesarean Delivery

Date of Discharge: _____ Blood Type: _____ Birth Weight: _____

Past Medical History: ☐ Check here if NONE.

Hospitalizations since birth (List reason and date)

_____

_____

Surgeries (List surgery and hospital/surgical center)

_____

_____

Specialists following child (List name of dr. and what for)

_____

_____

_____

Major Illness/Recurrent Illness

_____

_____

_____

_____

Temporary Problems

_____

_____

_____

_____

Current Prescription Medications: ☐ Check here if NONE.

Name	**Dose**	**Frequency**	**Reason**

Allergies (List any known allergies to medications or foods) ☐ Check here if NONE.

_____

_____

Social History

Who lives at home with the patient? ___mother ___father ___other adult (specify _____)

Pets? Y / N Smokers? Y / N

School/Daycare: Y / N If yes, where? _____

Recent foreign travel? Y / N If yes, where?_____

Is there a gun kept in the place where your child lives? Y / N Locked up/ammo separate? Y / N

Physician Reviewed: _____