

# Pediatric New Patient History Form

Today's Date: \_\_\_\_\_



## Patient Information



Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Sex: M / F Child SS#: \_\_\_ - \_\_\_ - \_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to patient? \_\_\_\_\_

Who May We Thank For Referring You? \_\_\_\_\_



## Infant General Health History

Type of Delivery: \_\_\_ Vaginal \_\_\_ Caesarean Section.

Were forceps or vacuum procedures used? \_\_\_\_\_. If yes, which one? \_\_\_\_\_

Was infant breach? \_\_\_\_\_ How many hours was Mom in hard labor? \_\_\_\_\_

Is infant breast or bottle fed? \_\_\_\_\_

If breast fed, is Mom on Medication's, Tobacco, or Alcohol? \_\_\_\_\_

Is Mom supplemented with Omega - 3's? (ie: flax seed or fish oil) \_\_\_\_\_

Has Infant been :

\_\_\_\_\_ spitting up \_\_\_\_\_ colicky \_\_\_\_\_ passing a lot of gas

\_\_\_\_\_ having regular bowel movements \_\_\_\_\_ holding head to one side

\_\_\_\_\_ sleepless \_\_\_\_\_ excessive crying \_\_\_\_\_ cranky

Others:

\_\_\_\_\_  
\_\_\_\_\_



# Toddler Questionnaire



Does your child suffer from any of the following:

\_\_\_\_\_ bed wetting \_\_\_\_\_ frequent ear infections \_\_\_\_\_ asthma



\_\_\_\_\_ difficult breathing \_\_\_\_\_ wheezing \_\_\_\_\_ ADHD

\_\_\_\_\_ hyperactivity



Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



\_\_\_\_\_

\_\_\_\_\_



Print Patient's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

