## BRADFORD FAMILY MEDICINE, INC. CHILD NEW PATIENT HISTORY

·		D	ate of Birth:	Today's Date:
(Last)	(First)	(MI)	Ralations	Today's Date:
Tarent/Guarulan.			Kelations	
<b>Medication Allergies: (Please lis</b>				
1			3	
2			4	
Medical Problems: (Please list a	ll past medical	problems a	and hospitalizations	)
	•	-	-	
2.				
3				
4				
5				
Birth History:	D' d I d		ADC AD C (101	`
Birth Weight:	Birth Length:		APGAR Scores (if k	nown):
How far from the pregnal	ncy due date?			
List any problems during	the present	lobor/doliva	war an nama and atom	
<b>Previous Surgeries:</b>				
2				
2				
2				
Medications: (Please include me	dication name	dose/frequ	ency as well as any	over-the-counter and herbal meds
Medications: (Please include me	dication name	dose/frequ	ency as well as any	over-the-counter and herbal meds
Medications: (Please include me	dication name	dose/frequ	ency as well as any	
Medications: (Please include medications: (Please include medications: 1	edication name/	/dose/frequ	34	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications: 2	dication name/	dose/frequence/dose/frequence/frequence/dose/frequence/f	as well as any 3. 4.	over-the-counter and herbal meds
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Medications: (Please include medications: (Please include medications: 1	ase list dates if a your immunizarchild visit:	applicable)	as well as any 3. 4.	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications: 1	ase list dates if a your immunizarchild visit:	applicable)	as well as any 3. 4.	over-the-counter and herbal meds
Medications: (Please include medulum 1	ase list dates if a your immunizarchild visit:	applicable)	as well as any 3. 4.	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications)  Routine Health Screening: (Please please provide a copy of Date of last routine well of Dental Care: (If applicable)  Last dental exam:  Social History:	ase list dates if a your immunizarchild visit:	applicable)	as well as any 3. 4.	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications)  Routine Health Screening: (Please please provide a copy of Date of last routine well of Dental Care: (If applicable)  Last dental exam:  Social History: Diet/Vitamins:	ase list dates if a your immunizatehild visit:	applicable)	as well as any 3. 4. Dentist:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications)  Routine Health Screening: (Please please provide a copy of Date of last routine well of Dental Care: (If applicable)  Last dental exam:  Social History: Diet/Vitamins:	ase list dates if a your immunizatehild visit:	applicable)	as well as any 3. 4. Dentist:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications)  Routine Health Screening: (Please provide a copy of Date of last routine well of Date of last routine well of Dental Care: (If applicable)  Last dental exam:  Social History: Diet/Vitamins:  Do you follow a special of Does the child take vitamedicates.	ase list dates if a your immunizatehild visit:  diet?Tynins/supplement	applicable)	as well as any 3. 4. Dentist:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medicated and include medicate	dication name/ ase list dates if a your immunizarchild visit:  diet?  Tynins/supplement  Prevention:	pe:s?	as well as any 3. 4. Dentist:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medicated and include medicated medicated and include medicated medicated and include medicated	dication name/ ase list dates if a your immunizate child visit:  diet?  Tynins/supplement  Prevention: r/household me	pe:	as well as any 3. 4. Dentist: Type/Frequency:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medicated and include medicated medicated and include medicated and includ	dication name/ ase list dates if a your immunizate child visit:  diet?  Typins/supplement  Prevention:  r/household mens about your child your	pe:ild's safety	at home?	over-the-counter and herbal meds
Medications: (Please include med 1	dication name/ ase list dates if a your immunizate child visit:  diet?  Typins/supplement Prevention: r/household me as about your ch ms installed?	pe: mbers: ild's safety _Carbon m	at home?onoxide detectors:	Anyone smoke at home?:
Medications: (Please include med 1	dication name/ ase list dates if a your immunizate child visit:  diet?  Typins/supplement Prevention: r/household me as about your ch ms installed?	pe: mbers: ild's safety _Carbon m	at home?onoxide detectors:	over-the-counter and herbal meds
Medications: (Please include medications: (Please include medications: 1	dication name/ ase list dates if a your immunizate child visit:  diet?  Typins/supplement Prevention: r/household me as about your ch ms installed? ur seatbelts?	pe:ild's safety _Carbon m _List any	at home? onoxide detectors: pets at home:	Anyone smoke at home?:
Medications: (Please include medications: (Please include medications: (Please include medications: Quality of the please provide a copy of Date of last routine well of Dental Care: (If applicable) Last dental exam:  Social History: Diet/Vitamins: Do you follow a special of Does the child take vitam Household Information/Injury I List the primary caretake Do you have any concern Do you have smoke alarm Do you use car seats/weat School/Daycare: (if applicable) Name of school/daycare:	dication name/ ase list dates if a your immunizate child visit:  diet?  Typins/supplement Prevention: r/household me as about your che ms installed? ur seatbelts?	pe: mbers: ild's safety _Carbon m _List any	at home? onoxide detectors: pets at home:	Anyone smoke at home?:
Medications: (Please include med 1	dication name/ ase list dates if a your immunizate child visit:  diet? Tynins/supplement Prevention: r/household mens about your chins installed? tr seatbelts?	pe:s?ild's safety _Carbon m	at home? onoxide detectors: pets at home:	Anyone smoke at home?:

## CHILD NEW PATIENT HISTORY Page 2

Patient Name: Date of Birth: Today's Date:						
Family History:						
Relative	Alive	Current Age/ Age of Death	Health Issues/Cause of Death (include all known issues including cancer types/stroke/heart issues /diabetes/etc.)			
Father						
Mother						
Siblings						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Other						