Providence Park Pediatrics New Patient Form

Child's Name: _____
Date of Birth: _____

Date of Form Completion: _____

BIRTH HISTORY:
Name of the hospital where infant was born: _____
Route of Delivery: ☐ Vaginal ☐ C-section
If c-section, please indicate reason for: _____
Gestational age at time of delivery: _____
Birth weight: _____
Did the baby need to go to the NICU or special care nursery? If so, please list reason
_____
Please indicate any medical problems or concerns during the newborn admission:
_____

CHILD'S PERSONAL MEDICAL HISTORY:
Please check if your child has been diagnosed with any of the following:

☐ ADD/ADHD
☐ Asthma
☐ Allergies
☐ Bleeding Disorder
☐ Anemia
☐ Breathing concerns
☐ Chicken pox
☐ Concussion
☐ Congenital heart disease
☐ Diabetes
☐ Eczema
☐ Fracture
☐ Handicap or disability
☐ Headaches
☐ Hearing problems
☐ High blood pressure
☐ Kidney disease
☐ Liver disease
☐ Recurrent ear infections
☐ Reflux/GERD
☐ Seizures
☐ Urinary tract infections
☐ Vision concerns
☐ Other

Please provide details of any positive responses:
_____
_____
_____
_____
_____

OTHER PROVIDERS:
Please list any other specialists your child has seen. Examples include ENT, allergist, therapist.

_____
_____
_____

MEDICATIONS: (include the name of the prescribed or over the counter medications, supplements and the dose)

_____
_____
_____
_____

Please list your **pharmacy** of preference (including location):

_____

ALLERGIES: Please list any allergies that your child has, including previous reactions:

_____
_____
_____
_____

HOSPITALIZATIONS:
Has your child ever been admitted to the hospital? ☐ Yes ☐ No
If yes, please list the reason why and when this occurred?

_____
_____
_____

SURGICAL/PROCEDURE HISTORY:
Please indicate any surgeries or procedures your child has had. Please include what the procedure was and the year it was performed

_____
_____
_____

SOCIAL HISTORY:
Who lives in the child's household? _____

If the child has any siblings, please list name and ages:

_____

_____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other: _____
Does anyone who lives with the child smoke? ☐ Yes ☐ No
Does the child's home have smoke detectors and carbon monoxide detectors?
☐ Yes ☐No
Is the water in the child's house ☐ fluorinated ☐ unfluoridated ☐ unknown
Are there any guns present in the child's house? ☐ Yes ☐ No
If yes, are they locked and stored separately from ammunition? ☐ Yes ☐ No
Does your child use a seat belt or car seat when in a vehicle? ☐ Yes ☐ No
What are your child's interests, hobbies?

_____

_____

GYN HISTORY: (if applicable)
Has your child started menstruating yet? ☐ Yes ☐ No
If yes, age of first period: _____ The date of when your last period started: _____

FAMILY HISTORY:
Please indicate if your child has a family history (parents, siblings, aunts/uncles, grandparents) of any of the following and the family member who has been diagnosed:
**Please specify maternal or paternal relation

☐ ADD/ADHD _____
☐ Allergies _____
☐ Asthma_____
☐ Autism _____
☐ Birth defects _____
☐ Blood disorders _____
☐ Cancer (include type) _____
☐ Congenital heart disease _____
☐ Other heart disease (ex heart attack, bypass, stents) _____
☐ Hearing problems/deafness _____
☐ Depression _____
☐ Developmental delay _____
☐ Diabetes _____
☐ Genetic Disorder _____
☐ High cholesterol _____
☐ High blood pressure _____

☐ Hip dysplasia _____
☐ HIV/AIDS _____
☐ Kidney disease _____
☐ Learning disability _____
☐ Liver disease _____
☐ Mental illness _____
☐ Migraines _____
☐ Scoliosis _____
☐ Seizure disorder _____
☐ Substance abuse _____
☐ Sudden unexplained death _____
☐ Stroke _____
☐ Thyroid disease _____
☐ Other (please specify): _____

Please include any additional information you feel we may need so that we can provide appropriate medical care for your child:

_____
_____
_____
_____

Please return prior to your appointment to ProvPeds@ascension.org