

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fracture | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Handicap or disability | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing concerns | <input type="checkbox"/> Headaches | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Vision concerns |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> 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 Yes No; carbon monoxide detectors Yes No

Is the water in the child's house fluorinated unfluorinated 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 and 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 (heart attack, bypass, stents) _____
- Deafness/hearing problems _____
- 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 provped@hfhs.org