MR#_____ **NEW PATIENTS** **DATE:**_____

PATIENT'S NAME: _____ DATE OF BIRTH: _____ Sex: Male / Female
RACE: _____ ETHNICITY: _____ LANGUAGE: _____
MOTHER'S NAME:_____ AGE:_____ PHONE #:_____
PLACE OF WORK & OCCUPATION:_____ PHONE #_____
FATHER'S NAME:_____ AGE:_____ PHONE #:_____
PLACE OF WORK & OCCUPATION:_____ PHONE #_____
PATIENT ALLERGIES:_____
SIBLING(S) NAME AND DATE OF BIRTH:_____
_____
_____

MEDICATION NAME	DOSE

BIRTH HISTORY: IF YES PLEASE EXPLAIN

Hospital Name		
Age at Discharge:		
Illnesses during pregnancy	NO	YES:
Any medications	NO	YES:
Alcohol/Drug Use	NO	YES:
Problems at birth/Premature	NO	YES:
Type of Delivery	Vaginal	C-section
Birth Weight	Birth:	Discharge Wt:
Feeding	Breastfeeding	Formula:

PATIENT HISTORY. PLEASE CHECK THE BOXES THAT APPLY TO YOUR CHILD'S HISTORY.

	Blood Disorder (Sickle Cell, Anemia)	
	Bone/ Joint Disorders (Arthritis, Gout)	
	Cancer	
	Diabetes	
	Eye Problems (Blindness, Lazy Eye, Crossing Eyes)	
	Ear Problems (Deafness, Recurrent Ear Infections)	
	Gastrointestinal (Ulcer, Crohn's, Celiac)	
	Genetic Disorders (Down Syndrome, Cystic Fibrosis)	
	Heart Disease (Heart Murmur, Congenital Heart Disease)	
	Kidney Disease (Urinary Tract Infection)	
	Lung Disorders (Asthma, Wheezing, Tuberculosis)	
	Muscle Disorders (Multiple Sclerosis)	
	Nervous Disorders (Migraines, Seizures, Epilepsy)	
	Psychiatric Disorders (Depression, ADHD, Anxiety, Bipolar)	
	Thyroid Problems	
	Other: (Developmental Delays, Autism, Sickle Cell Trait)	

MR#_____ **NEW PATIENTS** **DATE:**_____

Hospitalizations/Surgeries	Dates

Are there any problems we should be aware of? ☐ Yes ☐ No _____

_____

Are parents divorced or separated? ☐ Yes ☐ No

Child resides with: _____

FAMILY HISTORY. PLEASE CHECK THE BOXES WHERE CHILD'S BLOOD RELATIVES HAVE HAD ANY PROBLEMS.

	Mother	Father	Brother	Sister	Mother's side	Father's Side
Blood Disorder (Sickle Cell, Anemia)						
Bone/ Joint Disorders (Arthritis, Gout)						
Cancer						
Diabetes						
Eye Problems (Blindness, Lazy Eye, Crossing Eyes)						
Ear Problems (Deafness)						
Gastrointestinal (Ulcer, Crohn's, Celiac)						
Genetic Disorders (Down Syndrome, Cystic Fibrosis)						
Heart Disease (Heart Attacks, High Blood Pressure)						
High Cholesterol						
Kidney Disease						
Lung Disorders (Asthma, Tuberculosis						
Muscle Disorders (Multiple Sclerosis)						
Nervous Disorders (Migraines, Seizures, Epilepsy)						
Psychiatric Disorders (Depression, Suicide, Bipolar)						
Thyroid Problems						
Sexually Transmitted Diseases (HIV, Gonorrhea, Herpes)						
Alcoholism, Drug Dependency						
Smoker						
Other:						