

**Witham Health Services
Pediatrics – New Patient History Form**

Child's Name: _____ DOB: _____ Gender: M F
Phone #1: _____ Phone #2: _____ Language (primary): _____
Address: _____ City: _____ State: _____ Zip: _____

Race: (choose any)

- American Indian or Alaska Native Asian Native Hawaiian or other Pacific Islander
 Black or African American White Other Race
 Other Pacific Islander Prefer not to answer

Ethnicity: (choose one)

- Hispanic or Latino Not Hispanic or Latino Prefer not to answer

Parent / Legal Guardian #1

Name: _____ SS# _____ DOB: _____
Relationship to Patient: _____ Email Address: _____
Employer: _____

Parent / Legal Guardian #2

Name: _____ SS# _____ DOB: _____
Address (if different): _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____ Phone: _____
Employer: _____

Emergency Contact (Other than parent/legal guardian)

Name: _____ Relationship to Patient: _____
Phone #1: _____ Phone #2: _____

Insurance

Insurance Name: _____ Policy Holder: _____

NOTE: If you have secondary insurance please inform front office

Pharmacy

Pharmacy Name: _____ City: _____

All information above is correct and approved

Printed Name

Signature

Date

Birth History

Is your child adopted? Yes No Religion: _____

Birth Place: _____ Birth Weight: _____

Was the baby born more than a week before the due date (before 39 weeks)? Yes No

If Yes, how early? _____

Were there any problems with the delivery? _____

Any problems while in the nursery (jaundice, feeding problems, infections)? _____

Did your baby require admission to a neonatal intensive care unit? Yes No

If so, where? _____

Maternal Pregnancy History

Were there any problems during the pregnancy (diabetes, high blood pressure, infections)? _____

Did birth mother use alcohol, tobacco, or other drugs during this pregnancy? _____

Did birth mother take any medications during pregnancy? Please list: _____

Growth and Development

Have you had any concerns about your child's development? Yes No

Has a doctor ever told you that your child has growth or development delays? Yes No

School History

Year in School: _____

School Name: _____

Any learning or social problems in school? Yes No

Does your child attend special school or classes? Yes No

Has your child had behavior or discipline problems? Yes No

Has your child ever seen a psychologist or therapist? Yes No

Allergies

Please list any allergies to foods, medicines, insects, etc.: _____

Past Medical History

Previous Pediatrician: _____

As far as you know, has your child received all recommended vaccinations? Yes No

Has your child had any of the following?

- | | | | | | |
|-------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vision Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Speech Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Broken Bones | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotional Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Child Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexual Molestation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eczema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lead Exposure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Urinary Tract Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other medical problems not listed above: _____

Age of first menstrual period, if applicable: _____

Has your child ever stayed overnight in the hospital? Yes No

Age: _____ Reason: _____

Age: _____ Reason: _____

Has your child ever had surgery? Yes No

Age: _____ Reason: _____

Age: _____ Reason: _____

Family

Please list all family members (parents and all siblings). Include anyone who lives in the same household with the patient.

Relationship to Patient	Name (first and last)	Age	Health Problems	Lives with patient (Y/N)
Mother				
Father				

Family History

Has anyone had the following health problems? (Include the baby's parents, aunts, uncles, cousins, and grandparents.)

- Asthma Yes No
- Allergies Yes No
- Eczema Yes No
- Diabetes Yes No
- Cancer Yes No
- Bleeding Problems Yes No
- Anemia Yes No
- High Blood Pressure Yes No
- Heart Attack Yes No

- Seizures (convulsions) Yes No
- Birth Defects Yes No
- Death in Infancy Yes No
- Alcohol/Drug Problems Yes No
- Mental Retardation Yes No
- Thyroid Disease Yes No
- Mental or Emotional Problems Yes No
- Suicide or Suicide Attempt Yes No

Reviewed by Physician

Date