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 you child had any of the following?

Measles	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Chickenpox	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Hearing Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Broken Bones	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Emotional Problems	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Child Abuse	☐ Yes	☐ No
Ear Infections	☐ Yes	☐ No	Sexual Molestation	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Lead Exposure	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	Urinary Tract Infection	☐ Yes	☐ 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	Seizures (convulsions)	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Birth Defects	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Death in Infancy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Alcohol/Drug Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Mental Retardation	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Mental or Emotional Problems	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Suicide or Suicide Attempt	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No			

_____ _____

Reviewed by Physician *Date*