MOUNT CARMEL
Medical Group

**OFFICE USE ONLY**
MRN: _____

# PEDIATRIC NEW PATIENT HISTORY FORM

Welcome to our practice! We ask that you fill out this form (both pages) and complete all areas to the best of your knowledge. This will help us get to know you and your child better and target any issues or concerns you may have.

**Child's Name:**_____ **Birth Date:**_____ **Date:** _____

Birth Hospital: _____ (City: _____)

Mother's name:_____ Birth Date:_____ Occupation:_____

Father's name: _____ Birth Date:_____ Occupation:_____

Are parents? (circle all that apply) Married Single Separated Divorced Living together

Who does child live with? _____

Name of guardian (if applicable): _____ Relationship to child: _____

Names of brothers and sisters:_____

Please list any other members of the household:_____

Was your child adopted? Yes No If yes, at what age? _____ From what country/city? _____

Religious preference (optional): _____

## Mom's Pregnancy History:

Number of pregnancies before this child (including miscarriages): _____

How long was this pregnancy? (# of weeks): _____

How many months pregnant was mom when prenatal care was started for this child? _____

Please list any illnesses mom experienced during this pregnancy (such as high blood pressure, diabetes, thyroid problems): _____

_____

Please list any medications mom took during pregnancy: _____

Did mom smoke during pregnancy? Yes No Any alcohol consumption? Yes No Any drug use? Yes No

## Patient's Birth History:

How long was labor (in hours)? _____ Was labor induced? Yes No If yes, why? _____

At the time of delivery: (please circle all that apply)

Breech presentation C-section VBAC Breathing problems Vacuum Forceps

In the nursery: (please circle all that apply)

Neonatal ICU admission Antibiotics Lights for jaundice Blood transfusion Oxygen needed

Birth weight: _____ Birth length: _____ Discharge weight: _____

Apgars (if known): _____ Length of time in the hospital: _____

Newborn screen done in hospital? Yes No Hepatitis B vaccine given in the nursery? Yes No

Please describe any other problems: _____

_____

## Nutrition History:

Breast fed? Yes No Duration: _____

Formula fed? Yes No Type of Formula: _____ Duration: _____

At what age did your child start solid foods? _____ Does your child use a pacifier? Yes No

Is your child taking vitamins? Yes No Is your child using a fluoride supplement? Yes No

Any feeding problems? (circle all that apply)

Vomiting or reflux Colic Diarrhea Food allergies (please list): _____

**IMMUNIZATIONS: PLEASE PROVIDE US WITH AN UPDATED LIST OF YOUR CHILD'S IMMUNIZATIONS**

**Child's Name:**_____

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**Growth and Development:** (For children beyond the newborn period)

What age did your child do the following:

Sit alone _____ Walk alone _____ Start saying 1-2 words _____ Feed self _____

Potty trained (during the day) _____ Potty trained (at night) _____ Dress self _____

Talk in 2-3 word sentences _____

What grade is your child in? _____

Any school problems? _____

_____

Any behavior problems? _____

_____

**For Girls Only:** Have you started having periods? Yes No If yes, at what age? _____

**Medical History:**

Please list any medical conditions for which your child has been treated in the past. For example, any heart problems, jaundice, bone or joint problems requiring bracing/casting, chicken pox, allergies, asthma, eczema, recurrent ear infections, strep throat, etc.

_____

_____

_____

**Surgical History/Hospitalizations:**

Please list below any operations or hospitalizations your child has had with the date.

_____

_____

**Medications:**

Please list all of the medications your child is taking, including over the counter medications and herbal supplements. Please include dose and how often he/she takes this medication.

_____

_____

**Allergies:**

Please list all medications your child is allergic to and what occurs when he or she takes that medication.

**If your child has no known allergies, check this box:** ☐

_____

**Family History:**

For each of the following family members, please list their age (or age at death) and any illnesses including diabetes, high blood pressure, heart disease, cancer, kidney problem, lung problems, depression, allergies and arthritis.

| | |
|---|---|
| Child's Mother: | Dad's Father: |
| Child's Father: | Dad's Mother: |
| Mom's Father: | Child's Siblings: |
| Mom's Mother: | |

**Thank you for your time! Please sign and date below.**

Parent/Guardian_____Date: _____

Print Name: _____ Relationship to patient: _____

Physician _____ Date: _____