PREMIER PEDIATRICS

NEW PATIENT HISTORY FORM

Please answer as best as you can. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	
Previous or referring doctor:		**Date of last physical exam:**		

BIRTH AND DEVELOPMENT HISTORY

Problems with Pregnancy	☐ No ☐ Yes If yes, please explain: ____________
Pregnancy duration	☐ Full-Term ☐ Pre-term ________ wks. Any NICU stay? ☐ No ☐ Yes If yes, how long? ____________
Birth weight/length	__________ lbs __________ inches Feeding: ☐ Breast ☐ Formula
Hospital where born	☐ Munroe ☐ Shands ☐ Other ____________
Type of delivery	☐ Vaginal ☐ C-sec Any complications? ☐ No ☐ Yes If yes, please explain ____________
At what age did your child:	Smile ________ Roll Over ________ Sit alone ________ Walk ________ Talk ________ Toilet Train ___________
Does your child have any developmental /speech delay?	☐ No ☐ Yes If yes, please explain ☐Speech delay ☐ Autism ☐ Down Syndrome ☐ Other ____________

PAST MEDICAL HISTORY

Has your child:	Had a serious illness ☐ No ☐ Yes Ear infections ☐ No ☐ Yes Frequent Tonsillitis ☐ No ☐ Yes Ever been hospitalized ☐ No ☐ Yes Major Injury ☐ No ☐ Yes Surgery ☐ No ☐ Yes If Yes, ☐ Ear tubes ☐ Tonsils & adenoids removed ☐ Other____________ Is your child taking any medications? ☐ No ☐ Yes If Yes____________ Have allergies to medications? ☐ No ☐ Yes If Yes____________
Has your child had:	☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Meningitis ☐ Other ____________

Please explain any "Yes" answers: ____________

SOCIAL HISTORY

Child lives with:	☐ Mom ☐ Dad ☐ Both Parents ☐ Other guardian ____________

Daycare /School ☐ No ☐ Yes If school, what school & grade? ____________ Pets at home? ☐ No ☐ Yes

Smoking ? ☐ No ☐ Yes If Yes, ☐ Parent ☐ Self Alcohol/Drug Use? ☐ No ☐ Yes If Yes, ☐ Parent ☐ Self

CURRENT PROBLEMS

Does your child have any of the following :	**No**	**Yes**
Vision problems	☐	☐
Hearing problems	☐	☐
Allergies/Sinus problems ☐ Seasonal ☐ Year round	☐	☐
Breathing Problems ☐ Asthma ☐ Bronchitis ☐ RSV ☐ Pneumonia	☐	☐
Acid reflux/colic	☐	☐
Weight gain or loss	☐	☐
Diabetes	☐	☐
Heart problems	☐	☐
Skin Problems ☐ Eczema ☐ Psoriasis ☐other	☐	☐
Anemia	☐	☐
Bowel problems	☐	☐
Bedwetting	☐	☐
Bladder/Kidney problems	☐	☐
Frequent Headaches	☐	☐
Seizures/Neurological disorders	☐	☐
Thyroid problems	☐	☐
Sickle Cell Disease/Trait	☐	☐
Other: ____________ ____________	☐	☐

FAMILY HISTORY

Have any family members had the following:	**No**	**Yes**	**Who?**
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Allergies/Sinus problems ☐ Seasonal ☐ Year round	☐	☐	
Breathing Problems ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐COPD	☐	☐	
High Cholesterol	☐	☐	
Obesity	☐	☐	
Diabetes	☐	☐	
Heart Problems	☐	☐	
Skin Problems ☐ Eczema ☐ Psoriasis ☐other	☐	☐	
Anemia	☐	☐	
Cancer	☐	☐	
Infectious diseases ☐Hepatitis ☐TB ☐HIV	☐	☐	
Bladder/Kidney Problems	☐	☐	
Migraine Headaches	☐	☐	
Seizures/Neurological disorders	☐	☐	
Thyroid problems	☐	☐	
Sickle Cell Disease/Trait	☐	☐	
Genetic Disorders	☐	☐	
Mental Disorders	☐	☐	
Substance Abuse Issues	☐	☐	