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Pediatric New Patient Medical History Form

(please print and use black ink only)

Date: _____ Referred By: _____

Child's Name: _____ Nickname:_____

Date of Birth: _____ Age:_____ F_____ M_____

Home Address: _____

City:_____ State:_____ Zip:_____ Home Ph:_____

Previous Physician:_____ Date of Last Well Child Exam:_____

Mother's Full Name:_____ Father's Full Name:_____

Step-Mother's Full Name (If Applicable): _____

Step-Father's Full Name (If Applicable):_____

Custodial Provider's Full Name (If different from above): _____

Relationship to Patient:_____

Birth History

Birth Weight:_____ Pregnancy#:_____ Mom's Age:_____

Birth Was: Vaginal:_____ Cesarean:_____ Early:_____ Late:_____

If birth was early, how many weeks early?_____

If Cesarean, why? _____

Did mother have any illnesses/problems with her pregnancy? Yes:_____ No:_____

Explain:_____

Did the baby have any problems right after birth?_____

Explain:_____

Was initial feeding: Breast Milk:_____ Formula:_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

Smoke Cigarettes: Y:_____ N:_____ Amount:_____

Drink Alcohol: Y:_____ N:_____ Amount:_____

Use "Street" Drugs: Y:_____ N:_____ Type of Drug:_____

Use Prescription Drugs: Y:_____ N:_____ Type of Drug:_____

Current and Past History

Is your child currently on any medication? Y:___ N:___ Explain:_____

Does your child have any serious or chronic illnesses? Y:___ N:___ Explain:_____

Has your child had serious injuries or accidents? Y:___ N:___ Explain:_____

Has your child had any surgeries? Y:___ N:___ Explain:_____

Has your child ever been hospitalized? Y:___ N:___ Explain:_____

Is your child allergic to any medications? Y:___ N:___ Explain:_____

Has your child ever reacted to immunizations? Y:___ N:___ Explain:_____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia: Y:___ N:___ Explain:_____

Nasal allergies or eczema: Y:___ N:___ Explain:_____

Frequent ear infections or sore throat: Y:___ N:___ Explain:_____

Problems with ears or hearing: Y:___ N:___ Explain:_____

Problems with eyes, vision or teeth: Y:___ N:___ Explain:_____

Frequent headaches or other neurologic problems: Y:___ N:___ Explain:_____

Frequent abdominal pain: Y:___ N:___ Explain:_____

Constipation requiring doctor visits: Y:___ N:___ Explain:_____

Bladder/kidney problems or bedwetting: Y:___ N:___ Explain:_____

Any heart problems/murmur: Y:___ N:___ Explain:_____

Anemia or bleeding problem: Y:___ N:___ Explain:_____

Thyroid or other gland problem: Y:___ N:___ Explain:_____

Diabetes: Y:___ N:___ Explain:_____

ADD/ADHD: Y:___ N:___ Explain:_____

Autism Spectrum Disorder: Y:___ N:___ Explain:_____

Mental Health Issues: Y:___ N:___ Explain:_____

Use of drugs or alcohol: Y:___ N:___ Explain:_____

Household Information

Please List All Those Living in the Child's Home:

Name:_____ Age:_____ Relationship to Child:_____
Name:_____ Age:_____ Relationship to Child:_____
Name:_____ Age:_____ Relationship to Child:_____
Name:_____ Age:_____ Relationship to Child:_____
Name:_____ Age:_____ Relationship to Child:_____

Are there siblings not listed above? If so, please list their full names and ages and where they live:_____

_____

_____

_____

_____

Child Care:_____

Are there any smokers in the household? Y:_____ N:_____

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have any family members had the following:

Alcohol/Drug Abuse: Y:____ N:____ Who:_____ Comments:_____
Allergies: Y:____ N:____ Who:_____ Comments:_____
Asthma: Y:____ N:____ Who:_____ Comments:_____
Birth Defects: Y:____ N:____ Who:_____ Comments:_____
Blood Disorders: Y:____ N:____ Who:_____ Comments:_____
Bone Disorders: Y:____ N:____ Who:_____ Comments:_____
Cancer: Y:____ N:____ Who:_____ Comments:_____
Diabetes: Y:____ N:____ Who:_____ Comments:_____
Endocrine Disease: Y:____ N:____ Who:_____ Comments:_____
Ear/Nose/Throat: Y:____ N:____ Who:_____ Comments:_____
Eye Disorders: Y:____ N:____ Who:_____ Comments:_____
G.I. Disorders: Y:____ N:____ Who:_____ Comments:_____
Heart Disease: Y:____ N:____ Who:_____ Comments:_____

High Blood Pressure: Y:____ N:____ Who:_____ Comments:_____
High Cholesterol: Y:____ N:____ Who:_____ Comments:_____
Immune Disorders: Y:____ N:____ Who:_____ Comments:_____
Joint Problems: Y:____ N:____ Who:_____ Comments:_____
Kidney Disease: Y:____ N:____ Who:_____ Comments:_____
Liver Disease: Y:____ N:____ Who:_____ Comments:_____
Lung Disease: Y:____ N:____ Who:_____ Comments:_____
Migraines/Headaches: Y:____ N:____ Who:_____ Comments:_____
Metabolic Disorders: Y:____ N:____ Who:_____ Comments:_____
Obesity: Y:____ N:____ Who:_____ Comments:_____
Seizure Disorders: Y:____ N:____ Who:_____ Comments:_____
Skin Disorders: Y:____ N:____ Who:_____ Comments:_____
Stroke History: Y:____ N:____ Who:_____ Comments:_____
Thyroid Disorders: Y:____ N:____ Who:_____ Comments:_____
Mental Health History: Y:____ N:____ Who:_____ Comments:_____
Other Medical History:_____

_____

Financial - Insurance Information and Agreement

(please read through carefully and provide all necessary information)

Insured Patients:

We do not participate in any insurance plans so payment is required at time of service. However, you may submit Dr. Howard's superbill to your insurance company for any reimbursements.

Missed Appointment and/or Last Minute Cancellation:

If you miss or cancel an appointment with less than 24 hours prior notice, you will be charged 50% of the visit.* **Exceptions: illness, work, or childcare*

Please provide the requested credit card information below:

Credit Card #: _____ Exp. Date: _____

(Accepted Cards : Visa, MC, Discover)

By signing below, you are confirming that you have read and are in agreement with our policy. Thank you for your cooperation.

Signature: _____ Today's Date: _____

(parent, guardian, custodial provider)