New Patient Information

Patient Name ______________________________ DOB ______________________________

I. Prenatal History

Mother's age at birth of child ______________________________

Any problems with pregnancy ______________________________

Baby's birth weight ______________________________

Was the baby born via C-section or vaginal delivery? ______________________________

Did your baby have any problems in the hospital (i.e. jaundice, infection, other)? ______________________________

II. Past Medical History

Previous Physician ______________________________

Regular medications with dose (please list) ______________________________

Allergies to medications, foods, insect stings (please list) ______________________________

Chronic medical conditions (please list) ______________________________

Hospitalizations ______________________________

Surgeries ______________________________

Are immunizations up to date? Yes No

Please provide a copy of immunization history if not already on file.

Has your child had any of the following problems:

Hearing problems	Yes	No	Seizure	Yes	No
Vision problems	Yes	No	Urine or Kidney problems	Yes	No
Fatigue	Yes	No	Psychological problems	Yes	No
Eczema, hives, or skin condition	Yes	No	Anemia	Yes	No
Frequent ear infection	Yes	No	Muscle/Joint problems	Yes	No
Wheeze/Asthma problems	Yes	No	Developmental issues	Yes	No
Heart murmur/Heart problem	Yes	No			

Has your child had any other medical problems (please list)? ______________________________

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III. Family History

Does your child's parents, grandparents, or siblings have any of the following:

Anemia Asthma Allergies Diabetes High Blood Pressure Heart Conditions Seizures

Congenital Malformations or Syndromes Mental Illness Cancer

Other:________________________________

IV. Social History

Do you have city water? Yes No

Please list names and ages of all living in your home ________________________

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Do you and your children always use a carseat/seatbelt when riding in a car or other vehicle? Yes No

Are there smokers in your household? Yes No

Who ____________ Packs per day ____________

____________ Packs per day ____________

____________ Packs per day ____________

Will your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling? Yes No

Will your child live in or regularly visit a house with peeling or chipped paint build before 1967? Yes No

Does your home include any person being followed or treated for lead poisoning? Yes No

Are there pets in your household? Yes No If yes, what kind ________________________

Do you use child care outside of the home? Yes No

ONE Pediatrics, PLLC: All Star Pediatrics, East Louisville Pediatrics, One Pediatrics at Simpsonville, Prospect Pediatrics, South Louisville Pediatrics, Springs Pediatrics, and Oldham County Pediatrics.