NEW PEDIATRIC PATIENT – 5 YEARS TO 10 YEARS

CLAY PLATTE FAMILY MEDICINE
SUMMIT FAMILY AND SPORTS MEDICINE
COBBLESTONE FAMILY MEDICINE CLINIC
BARRY POINTE FAMILY CARE

Name: _____

Birth Date: _____ Sex: M F

Today's Date: _____

Please tell us the **REASON FOR TODAY'S VISIT**: _____

Please list **CURRENT MEDICATIONS**:

Name of Medication	**Dosage** (ie, milligrams)	**How taken** (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	**Type of Reaction** (ie, rash, nausea, swelling)

Are **IMMUNIZATIONS** up to date? Yes No **Please provide a copy of immunization record.**

BIRTH HISTORY:

Mother's age at child's birth: _____	Type of Delivery: _____Vaginal _____C-Section
Number of pregnancies: _____	Term: _____Full Term _____Premature
Was prenatal care given: Yes No	Birth Weight: _____lbs _____oz
Any problems after delivery or newborn nursery care? Yes No	Birth Length: _____inches

DEVELOPMENTAL HISTORY - Please complete for children age 5 ONLY:

Does/Can your child?	**Yes**	**No**
Counts 5 objects		
Counts to 10		
Draws people with 2-5 parts		
Follows directions		
Knows address/phone numbers		
Knows on/off, and over/under		
Plays cooperatively		

Does/Can your child?	**Yes**	**No**
Pretend play		
Prints name		
Rides bike with training wheels		
Skips		
Speaks understandably		
Tells imaginary stories		

For Nurse Use Only: Height_____ Weight_____ Temp_____ BP_____ Pulse_____ Resp_____

Please provide your **PAST MEDICAL HISTORY**:

_____ADD/ADHD
_____Abdominal Pain
_____Acne
_____Allergic Rhinitis
_____Allergies
_____Anemia
_____Asthma
_____Bleeding Disorder
_____Bronchiolitis
_____Bronchitis
_____Chickenpox
_____Concussion, CHI
_____Congenital heart disease
_____Constipation
_____Diabetes
_____Eczema
_____Fracture
_____GERD(reflux)
_____Headaches
_____Hearing problems
_____Heart murmur
_____Menstrual problems
_____Migraines
_____Pneumonia
_____Prematurity
_____Pyleonephritis
_____Recurrent otitis media
_____Seizure disorder
_____Seizures – febrile
_____UTI
_____Vesicoureteral reflux

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if know**n:

_____Appendectomy
_____Inguinal Hernia Repair
_____Fracture with Surgical Reduction
_____Dental Surgery
_____Tonsillectomy
_____Adenoidectomy
_____PET placement
_____Lymph node biopsy/excision
_____Umbilical Hernia Repair

Please list any **ADDITIONAL PAST MEDICAL HISTORY** or **PAST SURGICAL HISTORY** and date/year if known:

_____

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer, Type					
Coronary artery disease (heart disease)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Genetic disorder					
Hemoglobinopathy					

	Mother	Father	Sister	Brother	Other
High cholesterol					
High blood pressure					
Hip Dysplasia					
Learning disability					
Mental retardation					
Migraines DDH					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide your **SOCIAL HISTORY**:

Who lives with your child? _____

Tobacco Exposure	**Yes**	**No**
Are there smokers in the house?		
If yes, do they smoke outside only?		
Home Environment	**Yes**	**No**
What is the age of the home?		
Is the water chlorinated?		
Is the water fluoridated?		
Is there lead in the home?		
Education	**Yes**	**No**
School Name:		
School Grade:		
Does child have any learning disabilities?		
Does child have any special needs?		

Safety	**Yes**	**No**
Does your child use a bike/skate helmet?		
Does your child use seat belt in car?		
Do you use a booster seat in car?		
Are smoke detectors in the home?		
Is there a carbon monoxide detector?		
Are there firearms in the home?		
Are there pets in the home?		
If yes, what kind(s)?		