PEDIATRIC NEW PATIENT FORM

For Newborns: Please complete page 1
All Others: Please complete pages 1-2

Child's name: ______________________ Preferred nickname: ______________________

Parents' names: ______________________

Household Information:
Please list everyone living in your child's home.

Name	Age	Relationship	Occupation

If one or both parents are not living in the home, what is the custody arrangement? ______________________

What is parents' relationship status? (please circle) single / married / living together / separated / divorced

Prenatal and Birth History:

	Yes	No	Explanation
Any problems during pregnancy?			
Any alcohol, tobacco, prescription drug, or other drug use during pregnancy?			
Was birth within 2 weeks of due date?			
Born by C-section? If yes, why?			
Any delivery complications or problems with the baby after birth?			

Birth weight: ____________ Hospital of birth (name, city, state): ______________________

Family Medical History:
Have any family members (biological parents, siblings, grandparents, aunts, uncles) had any of the following? If yes, who?

Asthma	Anemia	Tuberculosis	Depression	Deafness
Allergy	Seizures	Mental Illness	Diabetes	Cancer
Eczema	Liver Disease	Kidney Disease	Alcohol/drug problems	Learning problems
Thyroid Disease	Vision problems	Bleeding disorder	HIV/AIDs	Birth defects
Heart Attack/Stroke before age 50	Childhood death	Eating disorder	Obesity	Scoliosis
Other:				

What specific issues do you wish to discuss with the doctor today? ______________________

____

Form completed by: ______________________
(Name) (Relationship) (Date)

1200 - 12th Ave. S., Seattle, WA 98144
www.pacmed.org

E0028 (Rev. 05/2011)

Patient Name:

DOB:

MRN:

Clinic Location:

PEDIATRIC NEW PATIENT FORM (continued)

Child's Medical History:

Please list any overnight hospitalizations or surgeries your child has had.

Reason for hospitalization	Age	Reason for surgery	Age

Does your child have, or has s/he ever had (please circle):

	Age		Age		Age
Frequent headaches		Heart problem or murmur		Scoliosis/back problems	
Dizziness, concussion		Frequent abdominal pain		Anemia or bleeding problem	
Problem with eyes or vision		Severe constipation		Skin problems	
Frequent ear infections		Bladder/kidney infection		Use of alcohol or drugs	
Problems with ears or hearing		Bedwetting/daytime accidents		Learning, attention or mood issues	
Nasal allergies, snoring		Seizures		For girls, start of menstrual period	
Asthma, wheezing, bronchiolitis		Diabetes		Chickenpox	
Pneumonia		Broken bones		Severe immunization reaction	
Food allergies		Speech problems		Eating disorder	
Serious Accidents		Menstrual problems		Physical development problems	
Other:					

Please list any drug allergies.

Medication	Reaction

Please list all current medications (including vitamins, herbs, and supplements).

Medication	Dosage	Prescribed by

Is your child up-to-date on immunizations? ______________________

Is there anything we should know about your child's diet (e.g. vegetarian, milk-protein allergy, etc.)? ______________________

Who was your child's previous doctor?

(Name) (Clinic) (Phone)

(Address) (Fax)

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