ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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NEW PATIENT INFORMATION

Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

FAMILY INFORMATION

(Please circle **PARENT / GUARDIAN** *and answer questions).*

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

DOB: _____/_____/_____ DOB: _____/_____/_____

Address:_____ Address: _____

Home #: _____ Work #: _____ Home #:_____ Work #: _____

Occupation/Employer: _____ Occupation / Employer:_____

Names of Sibling(s): _____ 2) _____

3) _____ 4) _____

Other Persons Living in Household: _____

PREGNANCY & BIRTH

Did Mother have any illness during pregnancy? NO YES: _____

Did Mother take any medications? NO YES: _____

Did Mother smoke or drink during pregnancy? NO YES: _____

Were there any problems with delivery? NO YES: _____

→ Type of delivery: Vaginal C-Section

→ Patient's birth weight: _____

Were there any problems after birth? YES NO

→ Mother: _____

→ Baby: _____

(Including: Breathing problems, Fever, Feeding difficulties & Jaundice).

PAST MEDICAL HISTORY

(Please circle "YES"or "NO" if applicable and list conditions related to the child).

Previous Doctor: _____

Date of last check-up: _____ Date of last dental exam: _____

Allergies? NO / YES: _____

Over»

Medications? _____

Do you have a record of immunizations? NO YES: (*Please provide us a copy*)

Reaction to any immunizations? _____

Has the patient had any medical problems? NO YES: _____

Has the patient been hospitalized, other than at birth? NO YES: _____

Has the patient had any serious injuries? NO YES: _____

Has the patient had any surgeries? NO YES: _____

FAMILY HISTORY

(Please check "YES" if applicable and list relatives as related to the child).

YES	RELATIVE	YES	RELATIVE
☐→ Anemia/Bleeding Problems	_____	☐→ Heart Attack/Disease	_____
☐→ Alcohol/Drug Problems	_____	☐→ High Blood Pressure	_____
☐→ Allergies	_____	☐→ High Cholesterol	_____
☐→ Asthma	_____	☐→ Immune Compromised	_____
☐→ Behavior/Learning/Speech Probs	_____	☐→ Kidney Disease	_____
☐→ Birth Defects	_____	☐→ Mental Retardation	_____
☐→ Cancer	_____	☐→ Muscle Disease	_____
☐→ Children with Heart Defects	_____	☐→ Psychiatric Illness	_____
☐→ Chronic Childhood Illness	_____	☐→ Seizures	_____
☐→ Deafness	_____	☐→ Spina Bifida	_____
☐→ Diabetes	_____	☐→ Thyroid Problems	_____
☐→ Early Childhood Death/SIDS	_____	☐→ Tuberculosis	_____
☐→ Other	_____		

DEVELOPMENTAL / BEHAVIOR

(Please circle "YES"or "NO" and answer questions).

Is the patient's development similar to others his/her age? YES NO

Does the patient get along with others his/her age? YES NO

Grade currently enrolled in: _____ School: _____

Teacher: _____

Has the patient ever been held back a grade in school? YES NO

Do you have any questions or concern that you would like to discuss with your doctor?

_____

_____

_____ .