



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: _____

Phone #: _____ Email: _____

Phone #: _____ Email: _____

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: _____

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).*

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