

## ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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Danielle Stratton, D.N.P.

## NEW PATIENT INFORMATION

Today's Date:/			
Patient Name:			
FAMILY INFORMATION (Please circle	PARENT / GUARDIAN and answer questions).		
Parent 1's Name:	Parent 2's Name:		
DOB:/	DOB:/		
Address:	Address:		
Ph#: Work #:			
Email:	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?  Did Mother take any medications?  Did Mother smoke or drink during pregnancy?  Were there any problems with delivery?  Type of delivery: Vaginal  Patient's birth weight:  Were there any problems after birth? YES  Mother:	NO		
• Baby:			
(Including: Breathing problems, I	Fever, Feeding difficulties & Jaundice).		
PAST MEDICAL HISTORY (Please circle "Y	YES" or "NO" if applicable and list conditions related to the child).		
Previous Doctor:			
Date of last check-up:	Date of last dental exam:		

Medications? NO /YES: (Please provide us a copy)  Reaction to any immunizations? NO /YES: (Please provide us a copy)  Reaction to any immunizations? Explain:  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  A Anemia/Bleeding Problems   Heart Attack/Disease   High Cholesterol   Allergies   High Cholesterol   Hi	Allergies? NO / YES:				
Reaction to any immunizations? Explain: 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:  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 Anemia/Bleeding Problems High Blood Pressure Alcohol/Drug Problems High Blood Pressure High Blood Pressure High Cholesterol Behavior/Learning/Speech Probs Brith Defects Brith Defe	Medications?		· · · · · · · · · · · · · · · · · · ·		
Has the patient been hospitalized, other than at birth? NO / YES:	•		_		
Has the patient been hospitalized, other than at birth? NO / YES:	Has the patient had any med	dical problems? NO			
Has the patient had any surgeries? 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					
FAMILY HISTORY   (Please check "YES" if applicable and list relatives as related to the child).    YES					
FAMILY HISTORY  (Please check "YES" if applicable and list relatives as related to the child).  YES  RELATIVE  Heart Attack/Disease  High Blood Pressure  High Cholesterol  High Cholesterol  High Cholesterol  High Cholesterol  High Cholesterol  Mental Retardation  Cancer  Mental Retardation  Cancer  Muscle Disease  Children with Heart Defects  Psychiatric Illness  Chronic Childhood Illness  Seizures  Deafness  Spina Bifida  Diabetes  Thyroid Problems  Tuberculosis  DEVELOPMENTAL / BEHAVIOR  (Please circle "YES" or "NO" and answer questions).  Is the patient's development similar to 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					
YES RELATIVE YES RELATIVE  Anemia/Bleeding Problems	Has the patient had any surg	geries? NO/YES:			
□ 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	FAMILY HISTORY (P	lease check "YES" if applice	able and list relatives as	related to the child).	
□ Alcohol/Drug Problems □ High Blood Pressure □ High Cholesterol □ High Cholesterol □ Immune Compromised □ Behavior/Learning/Speech Probs □ Kidney Disease □ Mental Retardation □ Cancer □ Muscle Disease □ Children with Heart Defects □ Psychiatric Illness □ Seizures □ Deafness □ Spina Bifida □ Diabetes □ Thyroid Problems □ Early Childhood Death/SIDS □ Tuberculosis □ Other □ Tuberculosis □ Tuberculosis □ Tuberculosis □ Steep Seizures □ Other □ School: □ School: □ Teacher: □ Has the patient ever been held back a grade in school? YES NO	YES	<u>RELATIVE</u>	<u>YES</u>	<u>RELATIVE</u>	
□ 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	$\square$ Anemia/Bleeding Problems		☐ Heart Attack/Disea	ase	
□ Asthma □ □ Immune Compromised □ Behavior/Learning/Speech Probs □ Kidney Disease □ Mental Retardation □ Cancer □ Muscle Disease □ Psychiatric Illness □ Seizures □ Sepina Bifida □ Diabetes □ Thyroid Problems □ Thyroid Problems □ Thyroid Problems □ Other □ Tuberculosis □ Other □ Tuberculosis □ Thyroid Problems □ Sepina Bifida □ Diabetes □ Thyroid Problems □ Thyroid Problems □ Serives □ Other □ Tuberculosis □ Thyroid Problems □ Thyroid Problems □ Serives □ Other □ Tuberculosis □ Other □ Tuberculosis □ Other □ Tuberculosis □ Other □ YES NO □ Other □ YES NO □ School: □ Teacher: □ School: □ Teacher: □ School: □ Teacher: □ YES NO □ The Patient ever been held back a grade in school? YES NO □ School: □ Teacher: □ YES NO □ The Patient ever been held back a grade in school? YES NO □ T	$\square$ Alcohol/Drug Problems		☐ High Blood Pressur	re	
□ Behavior/Learning/Speech Probs □ Kidney Disease □ Mental Retardation □ Muscle Disease □ Muscle Disease □ Psychiatric Illness □ Seizures □ Deafness □ Spina Bifida □ Diabetes □ Thyroid Problems □ Tuberculosis □ Other □ Tuberculosis □ Tuberculosis □ Tuberculosis □ Tuberculosis □ Tuberculosis □ Other □ 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	☐ Allergies		☐ High Cholesterol		
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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					
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Does the patient get along with others his/her age?  Grade currently enrolled in:  Teacher:  Has the patient ever been held back a grade in school?  YES NO  YES NO					
Grade currently enrolled in: School:  Teacher:  Has the patient ever been held back a grade in school? YES NO	•	•			
Teacher:  Has the patient ever been held back a grade in school? YES NO	-				
Has the patient ever been held back a grade in school? YES NO					
-	Teacher:				
Do you have any questions or concern that you would like to discuss with your doctor?	Has the patient ever been he	eld back a grade in sch	ool? YE	S NO	
Do you have any questions of concern that you would like to discuss with your doctor:	Do you have any questions of	or concern that you wo	uld like to discuss w	vith your doctor?	