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).*

Parent 1's Name: _____ Parent 2's Name: _____

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

Address:_____ Address: _____

_____ _____

Ph#: _____ Work #: _____ 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? 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: _____

Over»

Allergies? NO / YES: _____

Medications? _____

Do you have a record of 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
☐ 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?

_____

_____

_____