PIEDMONT PEDIATRICS

NEW PATIENT HISTORY FORM

Date _____

Name _____ DOB: _____

How were you referred to our practice? _____

Current problems/concerns _____

Allergies to (medications, foods, others?) _____

Current medications _____

BIRTH HISTORY

Was this child? Full term _____ Pre-term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? Vaginal _____ C-section _____ If C-section, why? _____

Any problems during the newborn period? _____

Birth weight _____ Breech? Yes _____ No _____

Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

CHILD'S PAST MEDICAL HISTORY	**Yes**	**No**	**If so, please describe:**
Any Hospitalizations?	☐	☐	_____
Any Surgeries?	☐	☐	_____
Any emergency room or urgent care visits?	☐	☐	_____

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	Yes	**No**
ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear infections	☐	☐
Chicken Pox	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problems? _____

Has your child ever been seen by a specialist? _____ If so, please describe: _____

HAS YOUR CHILD EVER EXPERIENCED THE FOLLOWING?

	Yes	No
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in the chest during exercise?	☐	☐

FAMILY HISTORY:

Do any family members have any of the following conditions? *Please explain: Grandmother/father, Aunt, Uncle, Cousin

Condition	Mother	Father	Sibling	* Extended Family (Maternal)	*Extended Family (Paternal)
High Blood Pressure	☐	☐	☐	☐ _____	☐ _____
High Cholesterol	☐	☐	☐	☐ _____	☐ _____
Prolonged QT	☐	☐	☐	☐ _____	☐ _____
Early heart attack (under 50 yrs. Old)	☐	☐	☐	☐ _____	☐ _____
Sudden unexplained death	☐	☐	☐	☐ _____	☐ _____
Anemia	☐	☐	☐	☐ _____	☐ _____
Bleeding or clotting disorder	☐	☐	☐	☐ _____	☐ _____
Allergies	☐	☐	☐	☐ _____	☐ _____
Autoimmune disorder	☐	☐	☐	☐ _____	☐ _____
Cancer	☐	☐	☐	☐ _____	☐ _____
Development/genetic disorder	☐	☐	☐	☐ _____	☐ _____
Diabetes	☐	☐	☐	☐ _____	☐ _____
Thyroid disease	☐	☐	☐	☐ _____	☐ _____
Polycystic Ovarian Syndrome (PCOS)	☐	☐	☐	☐ _____	☐ _____
Ear tubes	☐	☐	☐	☐ _____	☐ _____
Deafness	☐	☐	☐	☐ _____	☐ _____
Stomach problems	☐	☐	☐	☐ _____	☐ _____
Liver disease	☐	☐	☐	☐ _____	☐ _____
Celiac disease	☐	☐	☐	☐ _____	☐ _____
ADD/ADHD	☐	☐	☐	☐ _____	☐ _____
Migraines	☐	☐	☐	☐ _____	☐ _____
Autism	☐	☐	☐	☐ _____	☐ _____
Seizures	☐	☐	☐	☐ _____	☐ _____
Mental illness	☐	☐	☐	☐ _____	☐ _____
Drug/alcohol abuse	☐	☐	☐	☐ _____	☐ _____
Asthma	☐	☐	☐	☐ _____	☐ _____
Tuberculosis	☐	☐	☐	☐ _____	☐ _____
Kidney problems	☐	☐	☐	☐ _____	☐ _____
Lazy eye	☐	☐	☐	☐ _____	☐ _____
Hip dysplasia	☐	☐	☐	☐ _____	☐ _____
Other _____	☐	☐	☐	☐ _____	☐ _____

SOCIAL HISTORY:

Who lives in your child's home?

_____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Is your child in: Daycare? _____ School? _____ If so, what grade? _____

Does anyone in the house smoke? ☐ Yes ☐ No

Are there guns in the home? ☐ Yes ☐ No

If so, are they locked/secured? ☐ Yes ☐ No

Do you have any concerns about your child's school performance? _____

_____

Do you have any special concerns about your child? _____

_____

Is there anything more you would like us to know about your child? _____

_____

Form completed by: _____ Relationship to child: _____