New Patient History & Physical

Patient Name _____ DOB_____

Caregiver Name	Relationship	Address	Phone	Email
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Baby's Birth Length? _____ in

Baby's Birth Weight?_____#_____oz

Group B Strep Status? + / - (circle one)

Gestational Age? (i.e.How many weeks pregnant at delivery?)

How long was the infant in the hospital?_____days

Vaginal or C-Section? (circle one)

Was your infant in the NICU? Yes / no If Yes, how long?_____days

Were there complications to the pregnancy? (circle all that apply)

Urinary Tract Infection	Low Fluid	Diabetes
High Blood Pressure	Sexually Transmitted Disease	Pre-eclampsia
Alcohol Use	Smoking	Drug Use

Other_____

Mom's age at delivery?_____

Family History (circle whatever applies & the relationship)

Alcoholism/Drug Addiction	Diabetes
Cancer	Anemia
Cystic Fibrosis	Kidney Disease
High Cholesterol	Seizures
Heart Disease/High Blood Pressure	

Does your child have any allergies to medications? Y/N If yes, what drug and reaction?

_____

What Medications does your child currently take?_____
_____
_____

Does your child have any allergies to foods? Y/N If yes, what food and reaction?

_____

List any hospitalizations your child has had_____
_____
_____

Any Injuries?_____
_____

List any Surgeries and dates_____
_____

Social History

Who does your child live with? _____

Is your child exposed to smoke in the home or car? Y / N

Has your child ever been in Foster Care or adopted? Y / N

Has your Child ever had or been diagnosed with? (Circle all that apply)

Asthma	ADHD	Anemia
Behavior Problems	Allergies	Developmental Problems
Hearing problems	History of Abuse	Recurrent Ear Infections
Heart Defect	Heart Murmur	Constipation
Chronic Diarrhea	Seizures	Scoliosis
Visual Problems	Urinary Tract Infections	