PEDIATRIC INITIAL VISIT

Date: _____ Social Security #:_____ MR #: _____

Name: _____ Birthdate: _____

NEWBORN HISTORY

Prenatal Problems: _____

Birth Weight: _____ Length: _____ Term: _____ If no, # of weeks _____

Newborn Problems: i.e. breathing problems, jaundice, infection: _____

_____

Feeding: Breast: _____ Formula: _____ Type: _____

FAMILY HISTORY (Indicate Mother's side = M or Father's side = F)

Diabetes:_____	Heart Disease:_____	Allergies:_____
Asthma:_____	Cancer:_____	Seizures:_____
Sickle Cell Disease:_____	Kidney Disease:_____	Tuberculosis:_____
High Blood Pressure:_____	Bleeding Problems:_____	Smoker in house:_____

Other:_____

PATIENT LIVES WITH _____ Name , if not parent: _____

Mother's name: _____ Father's name: _____

Work Phone: _____ Work Phone: _____

Siblings: _____ Boys: _____ Girls: _____

Pets:_____

PATIENT HISTORY MEDICATION ALLERGIES: _____

Asthma:_____	Bleeding Problems:_____	Hay Fever:_____
Eczema:_____	Vision Problems:_____	Ear/ Hearing Problems:_____
Heart Problems:_____	Seizures:_____	School Problems:_____
Bladder/ Kidney Infection:_____	Stomach Problems:_____	Constipation:_____
Menses Began:_____	Other:_____	

Surgery/ Hospitalization:_____

Immunization Record:

☐ I have a copy of my child's record for the chart. ☐ I will bring in a copy of my child's record**.**