Crested Butte Pediatrics

Patient Name_____

Date of birth_____

New Patient History

Date_____

Form Completed by_____

Pregnancy and birth

Where was your child born?_____

This child is yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications ☐no ☐yes _____

_____

Was the child born early? ☐no ☐yes _____ weeks

Birth Complications _____

_____

Newborn problems _____

_____

Birth Weight _____

Past Medical History

Has your child ever been hospitalized overnight? ☐no ☐yes

What for? _____

Has your child ever had surgery? ☐no ☐yes _____

_____

Previous Primary Care Provider _____

Last seen and reason_____

Any specialist visits? ☐no ☐yes For? _____

_____

Any allergies to medications?_____

To Foods? _____

Other allergies?_____

Current medications, including over-the-counter medications:

_____

_____

Supplements, vitamins, herbal remedies?_____

_____

Has your child ever been diagnosed with:

Asthma or wheezing	☐no ☐yes
Nasal allergies or allergic rhinitis	☐no ☐yes
Eczema	☐no ☐yes
Intestinal or digestion problems	☐no ☐yes
Seizures or neurologic problem	☐no ☐yes
Learning Disability	☐no ☐yes
Anemia	☐no ☐yes
Broken bone	☐no ☐yes
Depression, anxiety, other mental illness	☐no ☐yes
Recurrent Infections	☐no ☐yes
Does your child have any chronic condition	☐no ☐yes
Has your child had any serious illness(es)	☐no ☐yes

Explanation and any other diagnoses: _____

_____

_____

_____

_____

Social History

Who does the child live with? _____

_____

Siblings in the home and ages_____

_____

Siblings not in the home_____

Other(s) in the home_____

Mother's occupation_____

Father's occupation_____

Pets? _____

Smokers? ☐no ☐yes

School_____

Family History

Does anyone in your family have any of the following conditions (including grandparents, aunts, uncles, and other extended family):

Attention problems (ADHD/ADD)	☐no ☐yes
Alcoholism	☐no ☐yes
Allergies	☐no ☐yes
Asthma	☐no ☐yes
Anemia	☐no ☐yes
Blood disorder	☐no ☐yes
Cancer	☐no ☐yes
Diabetes	☐no ☐yes
Depression	☐no ☐yes
Anxiety	☐no ☐yes
Developmental delay	☐no ☐yes
Drug abuse	☐no ☐yes
Heart disease/Heart attack	☐no ☐yes
High cholesterol	☐no ☐yes
High blood pressure	☐no ☐yes
Kidney disease	☐no ☐yes
Liver disease	☐no ☐yes
Migraines	☐no ☐yes
Seizures	☐no ☐yes
Stroke	☐no ☐yes
Thyroid disease	☐no ☐yes

Other:_____

_____

Do you have any concerns about your child's:

Development? ☐ no ☐ yes _____

Nutrition? ☐ no ☐ yes _____

Sleep? ☐ no ☐ yes _____

Other?_____

_____

_____

_____