PREMIER PEDIATRICS

NEW PATIENT HISTORY FORM

Please answer as best as you can. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name *(Last, First, M.I.):*		☐ **M** ☐ **F**	**DOB:**	
Previous or referring doctor:		**Date of last physical exam:**		

BIRTH AND DEVELOPMENT HISTORY

Problems with Pregnancy	☐ No ☐ Yes If yes, please explain: _____
Pregnancy duration	☐ Full-Term ☐ Pre-term _____ wks. Any NICU stay? ☐ No ☐ Yes If yes, how long? _____
Birth weight/length	_____ lbs _____ inches Feeding: ☐ Breast ☐ Formula
Hospital where born	☐ Munroe ☐ Shands ☐ Other _____
Type of delivery	☐ Vaginal ☐ C-sec Any complications? ☐ No ☐ Yes If yes, please explain _____
At what age did your child:	Smile _____ Roll Over _____ Sit alone _____ Walk _____ Talk _____ Toilet Train _____
Does your child have any developmental /speech delay?	☐ No ☐ Yes If yes, please explain ☐Speech delay ☐ Autism ☐ Down Syndrome ☐ Other _____

PAST MEDICAL HISTORY

Has your child:	Had a serious illness ☐ No ☐ Yes Ear infections ☐ No ☐ Yes Frequent Tonsillitis ☐ No ☐ Yes Ever been hospitalized ☐ No ☐ Yes Major Injury ☐ No ☐ Yes Surgery ☐ No ☐ Yes If Yes, ☐ Ear tubes ☐ Tonsils & adenoids removed ☐ Other_____ Is your child taking any medications? ☐ No ☐ Yes If Yes_____ Have allergies to medications? ☐ No ☐ Yes If Yes_____
Has your child had:	☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Meningitis ☐ Other _____

Please explain any "Yes" answers: _____

SOCIAL HISTORY

Child lives with:	☐ Mom ☐ Dad ☐ Both Parents ☐ Other guardian _____

Daycare /School ☐ No ☐ Yes If school, what school & grade? _____ Pets at home? ☐ No ☐ Yes

Smoking ? ☐ No ☐ Yes If Yes, ☐ Parent ☐ Self Alcohol/Drug Use? ☐ No ☐ Yes If Yes, ☐ Parent ☐ Self

CURRENT PROBLEMS			**FAMILY HISTORY**			
Does your child have any of the following :	**No**	**Yes**	**Have any family members had the following:**	**No**	**Yes**	**Who?**
Vision problems	☐	☐	High Blood Pressure	☐	☐	
Hearing problems	☐	☐	Stroke	☐	☐	
Allergies/Sinus problems ☐ Seasonal ☐ Year round	☐	☐	Allergies/Sinus problems ☐ Seasonal ☐ Year round	☐	☐	
Breathing Problems ☐ Asthma ☐ Bronchitis ☐ RSV ☐ Pneumonia	☐	☐	Breathing Problems ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐COPD	☐	☐	
Acid reflux/colic	☐	☐	High Cholesterol	☐	☐	
Weight gain or loss	☐	☐	Obesity	☐	☐	
Diabetes	☐	☐	Diabetes	☐	☐	
Heart problems	☐	☐	Heart Problems	☐	☐	
Skin Problems ☐ Eczema ☐ Psoriasis ☐other	☐	☐	Skin Problems ☐ Eczema ☐ Psoriasis ☐other	☐	☐	
Anemia	☐	☐	Anemia	☐	☐	
Bowel problems	☐	☐	Cancer	☐	☐	
Bedwetting	☐	☐	Infectious diseases ☐Hepatitis ☐TB ☐HIV	☐	☐	
Bladder/Kidney problems	☐	☐	Bladder/Kidney Problems	☐	☐	
Frequent Headaches	☐	☐	Migraine Headaches	☐	☐	
Seizures/Neurological disorders	☐	☐	Seizures/Neurological disorders	☐	☐	
Thyroid problems	☐	☐	Thyroid problems	☐	☐	
Sickle Cell Disease/Trait	☐	☐	Sickle Cell Disease/Trait	☐	☐	
Other: _____ _____	☐	☐	Genetic Disorders	☐	☐	
			Mental Disorders	☐	☐	
			Substance Abuse Issues	☐	☐	

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