NEW PATIENT MEDICAL HISTORY – Newborn to 6 months

Pediatrics of Sugar Land - Phone: 281-265-8800 Fax: 281-265-1770

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT
WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES

The following is **very important** to your child's health. Please complete it **accurately** and **completely**.

Child's Name: _____ **Birth Date**: ____/____/_____

Where was your child born? _____ Is child adopted or fostered? Y___ N___
Has your child **ever** previously been seen by any of the doctors **in this practice**? Y___ N___

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition
Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	**NO**	**YES**	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY	**No**	**Yes**	
Lives with both mother and father in same house			
Non-intact home - give custody status			Lives with:
Does non-custodial parent have visitation rights?			
Are there Siblings?			Live in same house?
Are there pets in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			
Other issues:			

Birth Weight:_____lb_____oz Birth Length:_____inches Head Cir_____ Chest_____

NEWBORN HISTORY – while in hospital	**No**	**Yes**	**If YES - explain**
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Did NOT get vitamin K and / or eye prophylaxis			
Feeding: Breast milk or formula? Or both?			Formula Type:
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening labwork (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first bowel movement			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopping breathing)			
Needed head ultrasound			
Needed ophthalmologic (eye) exam			
Was HEP B given in Hospital?			
Was Newborn Hearing done in Hospital			Pass or Did not Pass
Other issues:			
MOTHERS PRENATAL HISTORY	**No**	**Yes**	**If Yes - explain**
Was this an assisted conception (had to have help? getting pregnant)?			
Was this a High-Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before born?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Is Mother up to date on the TDAP Vaccine			
Other Issues:			

Is there anything else regarding your child's health that you think we should know that has not already been asked?

_____

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: _____ Relationship to patient: _____

Print Name: _____ Today's Date: _____/_____/_____