

Pediatric New Patient Form

What is your relationship to the patient?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Other relative <input type="checkbox"/> Guardian
Besides you, does anyone else take care of the child?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? :	
Who is the primary care provider for the child?	
How many times has the child moved in the last year?	
Where is the child living now?	
<input type="checkbox"/> House or apartment with family <input type="checkbox"/> House or apartment with relatives or friends <input type="checkbox"/> Shelter <input type="checkbox"/> Other If "other", please describe:	
Where else has your child received healthcare?	
List medications: prescribed, over-the-counter and natural remedies. Please include strength and dosing.	
Drug/medication allergy: Please list both the drug and describe the reaction that the child had.	
Has the child had immunizations?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Where?	
Do you have a copy of the immunization record?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Has the child been Hospitalized? Please list reason and approximate age. If no hospitalizations, please enter none.

Has the child had any Surgeries? Please list reason and approximate age. If no surgeries, please enter none.

Do you have any concerns about behaviors at home, daycare, school?

- Yes
 No

What are your main concerns about your child?

How would you rate this child's health, in general?

- Excellent
 Good
 Fair
 Poor

Does the child's mother, father, grandparents or siblings have any of the following?

High blood pressure

- Yes
 No

Lung problems, like asthma

- Yes
 No

Heart problems

- Yes
 No

Learning problems

- Yes
 No

Nerve problems

- Yes
 No

Anxiety or Depression

- Yes
 No

Diabetes

- Yes
 No

Drinking or Drug problems

- Yes
 No

Please help us by answering the following child safety questions.

How often does the child use a seatbelt/carseat?

- Always
 Never
 Often
 Rarely
 Sometimes

Does your child ride a bicycle?

- Yes
 No

If yes, how often does he/she use a helmet?

- Always
 Never
 Often
 Rarely

<p>Do you feel that you live in a safe place?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>In the past year, have you ever felt threatened in your home?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you feel that you live in a safe place?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you or threatened to hurt you?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>What kinds of guns are in your home?</p> <p><input type="checkbox"/> Handgun <input type="checkbox"/> Shotgun <input type="checkbox"/> Rifle <input type="checkbox"/> None</p>	<p>If you have a gun in your home, is it locked up?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Does anyone in your household smoke?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Your answers here are kept strictly confidential as part of your child's medical record</p>	
<p>In the past year have you ever had a drinking problem?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you tried to cut down on alcohol in the last year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>How many drinks does it take for you to get high or get a buzz?</p>	<p>Have you ever had a drug problem?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you ever had a drug problem?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you used any drugs in the last 24 hours?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If yes, which ones?</p> <p><input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Speed <input type="checkbox"/> Marijuana <input type="checkbox"/> Other</p>	<p>Are you in a drug or alcohol recovery program now?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>