New Patient Pediatric History Form

Troutman Family Medicine

Patient Name:_____ DOB :_____ Date:_____

Referred by: Bellsouth; Yellow pages; Yellow book; Alltel Phonebook; Newspaper; Physician _____ ; Friend _____; Family_____ Other_____

Describe your main problem _____

Where is your problem located?_____

How severe is your problem? _____

How long have you had this problem?_____

When does this problem occur?_____

Where were you when this problem started? _____

What other things happen with this problem?_____

What makes this problem worse or better? _____

List previous hospitalizations/Surgeries/Serious Injuries When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had the following?

Diabetes……	yes	no
Hypertension……	yes	no
Asthma……	yes	no
Thyroid trouble……	yes	no
Vision Problems……	yes	no
Stroke……	yes	no
Heart trouble……	yes	no
Arthritis/gout……	yes	no
Convulsions……	yes	no
Bleeding tendency……	yes	no
Skin Cancer……	yes	no
Hearing Problems……	yes	no
Hereditary defects……	yes	no
Cholesterol……	yes	no

ALLERGY:

Penicillin or other antibiotics	No	Yes
Morphine, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Iodine or other antiseptic…	No	Yes

Other drugs/medications

Known food allergies

Patient Social History

Parental Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ _____

Use of tobacco: ❑ Never ❑ Second Hand _____

Use of Drugs: ❑ Never ❑ Type/Frequency_____

Excessive exposure at home to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Sibling's	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____

Birth History

Term:_____ Feeding:_____

Birth Complications:_____

Jaundice:_____ Hospital:_____

List Medications you are currently taking

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

Prevention - Pediatrics	
	Date:
Complete Physical	
Skin check-Cancer Screening	
Cholesterol / Lipid test	
Flu Vaccine	
Meningitis	
Tetanus	
HPV	

Immunizations		
	Yes	**No**
Up to Date?		
Where done?		
Any shots missing?	**Yes**	**No**

Parent Signature: _____