<u>New Patient</u> Information and Medical History (Updated 12/2016)

Arundel Pediatrics, PA
Phone: 410-789-7337
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Child's Full Name_________________________________ **Date of Birth**________________

Address____ **City**______________________ **State**___________
Zip Code______________ **Phone Number**_____________________**Alternate Phone Number**______________________

Previous Doctor ____

How did you hear about us? ____

Mother's Name___________________________________ **Father's Name**______________________________________
Mother's Occupation______________________________ **Father's Occupation**_________________________________
Does mother live with Child? [ ] Yes [ ] No **Does father live with child?** [ ] Yes [ ] No

Legal Guardian Name______________________________ **Siblings Names/Birthdates:** ________________________________
Is the child adopted? [ ] Yes [ ] No
Is the child in foster care? [ ] Yes [ ] No

Mother's age at birth_______________ **Type of delivery** [ ] Vaginal [ ] C-section

Weight at birth ___________________

Was baby born early? [ ] Yes [ ] No **Number of day's baby stayed in the hospital after birth**__________

Check if mother had any of the following during pregnancy or delivery:
[ ] Infection [ ] Diabetes [ ] Drug/Alcohol use [ ] Cigarette use [ ] Early Labor [ ] Other complications

Medical History	**Yes**	**No**	**Explain (include dates if known)**
Does your child have any chronic conditions or diseases?			
Hospitalizations?			
Surgeries?			
Emergency room visits?			
Food Allergies?			
Medication allergies?			
Immunization reactions?			

Check if your child has *<u>ever</u>* had any of the following:
[ ] Chickenpox
[ ] Frequent ear infections (>5/yr)
[ ] Urinary tract infections
[ ] Frequent headaches
[ ] Heart Murmur
[ ] Seizures/Epilepsy
[ ] Anemia/low blood count
[ ] Loud snoring
[ ] Pneumonia
[ ] Depression/emotional problems
[ ] RSV/Bronchiolitis
[ ] Eating disorder/Anorexia
[ ] Stomach problems/reflux
[ ] Poor school performance
[ ] other explain below

Explain ____
____
____
____

Family History (This should include grandparents, aunts, uncles, etc. Please indicate which relative by illness)

[ ] ADD / ADHD ______________________________
[ ] Alcoholism/Drug Abuse ____________________
[ ] Allergies-nasal;Environmental,Food __________
[ ] Arthritis __________________________________
[ ] Asthma/RAD ______________________________
[ ] Autoimmune Disorder-Lupus,Psoriasis ________
[ ] Blood Disorder-Hemophilia,Sickle Cell, Bleeding Problems _________________________________
[ ] Bed Wetting ______________________________
[ ] Cancer ___________________________________
[ ] Complications from Anesthesia ______________
[ ] Congenital Birth Defects ____________________
[ ] Congenital Heart Disease-VSD, Tetrology, Single Ventricle _________________________________
[ ] Developmental Delay/Disorder-Austim, Speech Delay _____________________________
[ ] Diabetes- Onset under 25 yrs ________________
[ ] Down's Syndrome _________________________
[ ] Ear Problems-Cholesteotoma, Frequent Ear Infections _________________________________
[ ] Eczema __________________________________
[ ] Epilepsy/Seizures/Convulsions _______________
[ ] Eye Problems-Crossed eye, Glaucoma, Cataracts ____
[ ] Family Violence/Domestic Abuse _____________
[ ] Gastrointestinal Problems-Ulcers, IBS, Reflux, Inflammatory Bowel ________________________
[ ] Hearing Loss from birth-Congenital deafness ____ ____
[ ] Heart Disease-Under 50 yrs. __________________________
[ ] High Blood Pressure __________________________________
[ ] High Cholesterol/Triglycerides _________________________
[ ] Immune Disorder ____________________________________
[ ] Infant Death-SIDS ____________________________________
[ ] Kidney Disease/problems _______________________________
[ ] Learning Disabilities __________________________________
[ ] Liver Disease-Jaundice _________________________________
[ ] Mental Illness-Depression, Anxiety _____________________
[ ] Mental Retardation ___________________________________
[ ] Migraines ____
[ ] Obesity ____
[ ] Schizophrenia ____
[ ] Scoliosis ____
[ ] Sexually Transmitted Disease-AIDS, Syphilis ______________
[ ] Stroke-Under 50 yrs. __________________________________
[ ] Sudden Athletic Death-Arrhythmia ______________________
[ ] Tuberculosis (TB) ______________________________________
[ ] Thyroid/Hormone Problems _____________________________
[ ] Rare Disease-Cystic Fibrosis, Multiple Sclerosis, Muscular Dystrophy, Neurofibromatosis ________________________
[ ] Explanations/Other Family Health Issues ________________
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Please list any health concerns you have ____
____
____

Please list any medication your child is currently taking _______________________________
____
____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No

The following individuals are able to authorize medical treatment for my child(ren) in my absence:

Name ______________________________ Relationship to Patient __________________________
Name ______________________________ Relationship to Patient __________________________
Name ______________________________ Relationship to Patient __________________________
Name ______________________________ Relationship to Patient __________________________
Name ______________________________ Relationship to Patient __________________________
Name ______________________________ Relationship to Patient __________________________

P**arent or Guardian Signature** ______________________________ **Today's Date** ______________