Bristol Health Medical Group

PEDIATRIC NEW PATIENT HISTORY INFORMATION

Today's Date_____

Child's Name _____ **Preferred Name** _____**Date of Birth** _____

Form Filled Out By _____ **Relationship to Patient** _____

Patient's Sex at Birth ___ Male ___ Female

Specify if desired:
Gender Identity ___Male ___Female ___Transgender M to F ___ Transgender F to M ___Non-binary ___ Other
Preferred Pronouns ___He/Him ___She/Her ___They/Them ___Other

Allergies (include type of reaction/symptoms) _____

Does your child have special needs? ___ Yes ___ No If yes please specify _____
_____

CHILD'S HEALTH HISTORY - Circle all that apply

Premature Birth/NICU Stay	Allergies (food/seasonal/environmental)	Autoimmune/Rheumatologic Disease
Hip Dysplasia (Congenital)	Asthma/Lung Problems/Pneumonia	Diabetes (Type 1 / Type 2)
Developmental Delay/Disability	Repeated Wheezing Episodes	Chicken Pox (Disease)
Autism	Heart Problems	Mono / Mononucleosis Virus
Growth Problems	High Blood Pressure or High Cholesterol	Tuberculosis / + PPD (skin test)
Hearing Loss/Ear Problems	Digestive/Gastrointestinal Problems	HIV / AIDS
Vision/Eye Problems	Liver Problems	Immune Problem
Genetic Disorder	Kidney Problems	Cancer
Obesity/Overweight	Urinary Problems/Infections (UTI)	Eating Disorder
Anemia or 'low iron'	Eczema/Skin Problems	Mental Illness (depression, anxiety, etc)
Bleeding Disorder or Blood Clots	Bone/Joint/Muscle Problems or Injuries	Past Suicide Attempt
Dental Problems	Scoliosis/Spine Problems	Behavior Problems
Thyroid Problem	Migraines/Chronic Headaches	ADHD or Learning Disability
Snoring/Sleep Apnea	Epilepsy/Seizure Disorder	Other _____

Do you believe your child's vaccines are up to date? ___ Yes ___ No ___ Uncertain

Do you intend to vaccinate your child (or catch up on missing doses) according to the recommended CDC vaccine schedule)?

___ Yes ___ No ____ Undecided

PAST HOSPITALIZATIONS, SURGERIES (including reason, date/age, location)	**LIST ANY SPECIALSTS THE CHILD SEES** (including name, location and specialty)

- Please turn over to complete page 2 -

CHILD'S NAME: _____ Date of Birth _____

HAS ANY FAMILY MEMBER HAD THE FOLLOWING?
(Include parents, siblings, grandparents and blood related aunts and uncles)
If yes please circle and specify which relative(s) affected

Illness	**Relative Affected**	**Illness**	**Relative Affected**
Genetic Disorder		Digestive/Gastrointestinal Problems	
Allergies – type?		Liver and/or Kidney Disease	
Asthma		Hip Disease/Dysplasia	
Eczema		Arthritis (under 55yo)	
Anemia/Low Blood Count/Low Iron		Autoimmune/Rheumatologic Disease	
Bleeding Disorder		HIV/AIDS	
Blood Clots (legs/lungs)		Immune Problems/Immunosuppressed	
Childhood Hearing Loss		Cancer	
Childhood Vision Problems		Tuberculosis	
High Blood Pressure (under 50yo)		Epilepsy/Seizures	
High Cholesterol (+/- Medication)		Alcohol/Drug Abuse	
Obesity		Mental Illness/Depression/Anxiety	
Diabetes (Type 1 / Type 2)		Developmental/Learning Problems	
Heart Disease/Stroke (under 55yo male / 65yo female)		Other Significant Diagnosis _____	
Sudden Death (under 55yo male / 65yo female)			

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER & HERBAL SUPPLEMENTS:

Medication Name	**Medication Dose**	**# Times per Day**	**Who Prescribed the Medication**