OhioHealth

MRN (office use only):________

New Patient History Form (Pediatric)

Please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and your child plus target any concerns/issues you may have.

Child's Name: ______________________________ Date of Birth: ____________ Date: ______________

Child's Place of Birth: ______________________________ City: ______________________________

Mother's Name: ___________________________Date of Birth: _________Profession:_________________

Employer: ______________________________ Work #:_______________Home #:_________________

Father's Name: ___________________________Date of Birth: _________Profession:_________________

Employer: ______________________________ Work #:_______________Home #:_________________

Parent's Status: Married Single Separate Divorced Living Together

Who does the child live with? ____

Name of guardian (if applicable):____________________________ Relationship to child: _________________

Name of siblings: ____

List other members in the household: ____

Was your child adopted? **Y N** If yes, at what age?_______ From what country/city_________________________

Religious preference (voluntary): ____

Mom's Pregnancy History

Number of pregnancies before this child (including miscarriages)________________________________

How long was this pregnancy (# of weeks)____

When was prenatal care started for this child (months pregnant): ______________________________

List any illnesses you experienced during this pregnancy (high blood pressure, diabetes, thyroid problems)

____

List any medications you took during the pregnancy: ______________________________________

Did you smoke during pregnancy? **Y N** Any alcohol consumption? **Y N** Any drug use? **Y N**

Patient's Birth History:

Length of labor (hours) _______ Was labor induced? Y N If yes, why? ______________________________

Delivery: (circle all that applies) Breech presentation C-section VBAC Breathing problems Vacuum Forceps

Nursery: (circle all that applies) Neonatal ICU admission Antibiotics Lights for jaundice Blood transfusion Oxygen needed

Birth weight: _______ Birth length: _______Discharge weight: _______ Apgar score: ____ Time spent in hospital: _______

Newborn screen performed in hospital? **Y N** Hepatitis B vaccine given in nursery? **Y N**

Please describe any other problems:____

____

Nutrition History:

Breast fed? **Y N** Duration:_______ Formula fed? **Y N** Type of formula:__________ Duration: _______

At what age were solid foods introduced? _______ Does your child use a pacifier? **Y N**

Is your child taking vitamins? **Y N** Is your child using a fluoride supplement? **Y N**

Any feeding issues? (circle all that apply) Vomiting or reflux Colic Diarrhea

Food allergies? (please list):____

IMMUNIZATIONS: PLEASE PROVIDE US WITH AN UPDATED LIST OF YOUR CHILD'S IMMUNIZATIONS

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Child's Name: ____

<u>Growth and Development:</u> (for children beyond the newborn period)

What age did your child perform the following?

Sit alone: _____ Walk alone: _____ Start saying 1-2 words: _____ Feed self: _____

Potty train (day): _____ Potty train (night): _____ Dress self: _____

Talk in 2-3 word sentences: _____ What grade is your child in? _______

Any problems in school? ____

____

Any behavioral problems? ____

____

<u>For Girls Only:</u> Have you started your period? Y N If yes, at what age? ______

<u>Medical History:</u>

Please list any medical conditions your child has been treated for in the past. Examples: heart problems, bone or joint problems (bracing/casting), jaundice, allergies, chicken pox, eczema, asthma, strep throat, recurring ear infections, ect.

____

____

<u>Surgical History / Hospitalization:</u>

Please list any operations or hospitalizations your child has had. Please include the dates.

____

____

<u>Medications:</u>

Please list medications your child is currently taking, this includes over the counter medications and herbal supplements.

____

____

<u>Allergies:</u>

Please list the medications your child is allergic to and what happens when he or she takes that medication.

Please check box if you have no known allergies: □

____

<u>Family History:</u>

Please list the age (or age at death) and any illnesses for the following family members. This includes diabetes, heart disease, kidney problems, cancer, high blood pressure, depression, arthritis, and allergies.

Child's Mother:	**Child's Father:**
Mom's Mother:	**Mom's Father:**
Dad's Mother:	**Dad's Father:**
Child's Siblings:	

Thank you for taking time to fill out the forms. Please sign and date:

Parent/Guardian: ____ Date: ____________________________

Print Name: ____ Relationship to patient: ____________________________

Physician: ____ Date: ____________________________