Corpus Christi Pediatrics **New Patient History Form** Date _____

Name _____ Date of Birth _____

How were you referred to our practice? _____

Current problems/concerns _____

_____

_____

_____

Allergies (medications, food, other) _____

_____

Current Medications _____

_____

Birth History

Was this child: Full Term _____ Pre-Term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery: Vaginal _____ C-Section _____ If c-section, why? _____

Any problems during the newborn period? _____

Birth Weight _____ Breech? Yes _____ No _____

Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

Child's Past Medical History

Any hospitalizations: ☐ Yes ☐ No

If yes, please describe _____

_____

Any surgeries: ☐ Yes ☐ No

If yes, please describe _____

_____

Any emergency room or urgent care visits: ☐ Yes ☐ No

If yes, please describe _____

_____

_____

Social History

Who lives in your child's home? _____

If parents are not living together or if child does not live with parents, what is the child's custoday status?

_____

Is your child in: Daycare? _____ School? _____ Is so, what grade? _____

Does anyone in the house smoke? ☐ Yes ☐ No

Are there guns in the home? ☐ Yes ☐ No

If so, are they locked/secured? ☐ Yes ☐ No

Are they unloaded? ☐ Yes ☐ No

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Has your child ever been treated for any of the following?

ADHD/ADD	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Suizures	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Ear Infections	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Urinary Tract Infection	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Serious Injury or Concussion	☐ Yes	☐ No
Developmental and/or speech problems	☐ Yes	☐ No
Has she started her menstrual cycle?	☐ Yes	☐ No
Fainting during or after exercise, emotion, or startle?	☐ Yes	☐ No
Extreme shortness of breath with exercise?	☐ Yes	☐ No
Discomfort, pain, or pressure in chest during exercise?	☐ Yes	☐ No

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Family History

Check family members that have any of the following conditions. For extended family note if it was a grandmother/father, aunt, uncle, cousin, etc — and what side of the family, maternal (m) or paternal (p).

Condition	Mother	Father	Sibling	Extended Family	Extended Family
High Blood Pressure	☐	☐	☐		
High Cholesterol	☐	☐	☐		
Prolonged QT	☐	☐	☐		
Early Heart Attack (under 50 yrs old)	☐	☐	☐		
Sudden Unexplained Death	☐	☐	☐		
Anemia	☐	☐	☐		
Bleeding or Clotting Disorder	☐	☐	☐		
Allergies	☐	☐	☐		
Autoimmune Disorder	☐	☐	☐		
Cancer	☐	☐	☐		
Development/Genetic Disorder	☐	☐	☐		
Diabetes	☐	☐	☐		
Thyroid Disease	☐	☐	☐		
Polycistic Ovarian Syndome (PCOS)	☐	☐	☐		
Ear Tubes	☐	☐	☐		
Deafness	☐	☐	☐		
Stomach Problems	☐	☐	☐		
Liver Disease	☐	☐	☐		
Celiac Disease	☐	☐	☐		
ADD/ADHD	☐	☐	☐		
Migraines	☐	☐	☐		

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Family History (continued)

Check family members that have any of the following conditions. For extended family note if it was a grandmother/father, aunt, uncle, cousin, etc — and what side of the family, maternal (m) or paternal (p).

Condition	Mother	Father	Sibling	Extended Family	Extended Family
Autism	☐	☐	☐		
Seizures	☐	☐	☐		
Mental Illness	☐	☐	☐		
Drug/Alcohol Abuse	☐	☐	☐		
Asthma	☐	☐	☐		
Tuberculosis	☐	☐	☐		
Kidney Problems	☐	☐	☐		
Lazy Eye	☐	☐	☐		
Hip Dysplasia	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		

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Background Info

Other history of chronic problems? _____

Has your child ever seen a specialist? _____

Do you have any concerns about your child's school performance? _____

Do you have any special concerns about your child? _____

Is there anything more you would like us to know about your child? _____

Signature of Parent/Legal Guardian

Date

Print Name of Parent/Legal Guardian

Relationship to Child