RAINBOW PEDIATRICS

NEW PATIENT HISTORY FORM

NAME		
DOB	AGE	M F

Household			
Please list all those living in the child's home			
Name	Relationship to child	DOB	Health Problems

Birth History	Social History
Delivery: vaginal C-sec Complications? Yes No	Day care: Yes No
Full term Pre Term _______wks	Smoker? Yes No
Birth weight: ____ lbs. Feeding: Breast Formula	Pets: Yes No
During pregnancy did mom:	**Child's immunizations are up to date** Yes No
Smoker yes no **Drink Alcohol** Yes No **Use Street Drugs** yes no	**Child has allergies to medications** Yes No

Past Medical History: Does your child have or has s/he ever had:	Yes	No	**Family History:** Have any of family members had the following:	**Yes**	**No**	**Who?**
Development /Mental delay			Seasonal or year round allergies			
Problems with vision or hearing			Bleeding disorders			
Acid Reflux (GERD), Colic			Heart problems (before 50 yrs. Old)			
Ear Infections: few many ear tubes			High blood pressure (before 50 yrs. Old)			
Strep Throat: few many tonsils & adenoids removed			Sudden death in younger age (<30yrs)			
Sinus problems			Sinus problems			
Chest colds: few many			Asthma, Bronchiolitis, Pneumonia, Emphysema			
Asthma, Bronchiolitis, Pneumonia			Nebulizer/inhaler use:			
Past nebulizer/inhaler use: few many			Diabetes (before 50 yrs. Old)			
Seasonal or year round allergies			TB/HIV			
Chronic or recurrent skin problems/Eczema			Cancer			
Hearth problems			Kidney disease			
Anemia or bleeding problems			Betting (after age 10 yrs old)			
Constipation requiring doctor visits			Chronic or recurrent skin problems			
Betting (after age 5 yrs old)			Deafness (born with)			
Frequent headaches			Liver disease			
Convulsions or other neurologic problems			Epilepsy or Convulsions			
Chicken pox			Migraine headaches			
Thyroid or other endocrine problems			Behavioral/mental problems			
Bladder or kidney infection			Obesity			
ADHD/Behavioral/Mental problems			Alcohol abuse			
(For girls) has she started per periods? (For girls) Are problems with periods?			Does your child have any other conditions not mentioned above			
Surgery			**Date Completed:**			
Hospital admissions			**Form Completed By:**			