# PEDIATRIC INITIAL VISIT

Date: _____ Social Security #:_____ MR #: _____

Name: _____ Birthdate: _____

**NEWBORN HISTORY**

Prenatal Problems: _____

Birth Weight: _____ Length: _____ Term: _____ If no, # of weeks _____

Newborn Problems: i.e. breathing problems, jaundice, infection: _____

_____

Feeding: Breast: _____ Formula: _____ Type: _____

**FAMILY HISTORY** (Indicate Mother's side = M or Father's side = F)

| | | |
|---|---|---|
| Diabetes:_____ | Heart Disease:_____ | Allergies:_____ |
| Asthma:_____ | Cancer:_____ | Seizures:_____ |
| Sickle Cell Disease:_____ | Kidney Disease:_____ | Tuberculosis:_____ |
| High Blood Pressure:_____ | Bleeding Problems:_____ | Smoker in house:_____ |

Other:_____

**PATIENT LIVES WITH** _____ Name , if not parent: _____

Mother's name: _____ Father's name: _____

Work Phone: _____ Work Phone: _____

Siblings: _____ Boys: _____ Girls: _____

Pets:_____

**PATIENT HISTORY** MEDICATION ALLERGIES: _____

| | | |
|---|---|---|
| Asthma:_____ | Bleeding Problems:_____ | Hay Fever:_____ |
| Eczema:_____ | Vision Problems:_____ | Ear/ Hearing Problems:_____ |
| Heart Problems:_____ | Seizures:_____ | School Problems:_____ |
| Bladder/ Kidney Infection:_____ | Stomach Problems:_____ | Constipation:_____ |
| Menses Began:_____ | Other:_____ | |

Surgery/ Hospitalization:_____

**Immunization Record:**

☐ I have a copy of my child's record for the chart. ☐ I will bring in a copy of my child's record.