

HOWARD COUNTY PEDIATRICS, LLC.

New Patient Information and Medical History

Child's Full Name _____ Date of Birth _____

Previous Doctor(s) _____ Phone # _____

Address _____

How did you hear about us? _____

Parent Name _____

Relation _____

Occupation _____

Does this parent live with child? Yes No

Parent Name _____

Relation _____

Occupation _____

Does this parent live with child? Yes No

Legal Guardian Name _____

Is the child adopted? Yes No

Is the child in foster care? Yes No

Name of siblings/Birthdates _____ / ____ / ____

_____ / ____ / ____

_____ / ____ / ____

_____ / ____ / ____

Mother's age at birth _____

Birth weight _____ lbs _____ oz

Was baby born early? Yes No

Type of delivery Vaginal C-section

Number of days baby stayed in hospital after birth _____

Check if mother had any of the following during pregnancy or delivery:

Infections Diabetes Drug/alcohol abuse Cigarette use Early labor Other complication

Medical History

	Yes	No	Explain (include dates if known)
Does your child have any chronic conditions or diseases?			
Hospitalizations?			
Surgeries?			
Emergency room visits?			
Food allergies?			
Medication allergies?			
Immunization reactions?			

Check if your child has ever had any of the following:

Chickenpox

Frequent ear infections (>5/yr)

Urinary tract infection

Frequent headaches

Heart murmur

Seizures/Epilepsy

Anemia/low blood count

Loud snoring

Pneumonia

Depression/ emotional problem

RSV/Bronchiolitis

Eating disorder/Anorexia

Stomach problems/reflux

Poor school performance

Other:

Please list any health concerns you have _____

Please list any medication your child is currently taking _____

Do you have any concerns about your child's development or behavior? Yes No Not sure

Family History

Check if a family member *other than the child* has ever had any of the following – WHO?

Asthma

Diabetes

Heart disease before age 55

High cholesterol

High blood pressure

Sudden death from unknown cause

Complications from anesthesia

Schizophrenia

Depression

Cancer

HIV/AIDS

Thyroid problems

Kidney problems

Tuberculosis

Sickle cell disease

Parent or Guardian Signature _____ Today's Date _____

Reviewed By: _____ Date: _____