Ashe Pediatrics
New Patient History Form

Date: _____

Child's Name: _____ DOB: _____

How were you referred to our practice? _____

Current problems/concerns: _____

Current Medications: _____

Birth History:

Was this child? Full Term _____ Pre-Term _____ Birth Hospital: _____ Gestation weeks _____

If adopted, at what age? _____

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

Any problems during newborn period? _____

Birth weight _____ Breech: Yes No Breast or Formula _____ If formula, what kind? _____

Passed hearing screen? Yes No Passed newborn screen? Yes No

Social History:

Who lives in child's home _____

Please circle custody status of child: *With mother, father, both parents, grandparent or guardian*

Siblings: _____

Pets: _____

Smokers: _____

Guns in the home: Yes No If yes, are they locked and kept separate from ammunition? Yes No

Please answer following questions:

Has your child ever fainted? Yes No

Has your child experienced extreme shortness of breath with exercise/activity? Yes No

Has your child ever had chest pain or pressure during or after exercise/activity? Yes No

Has your child ever been seen by a specialist? Yes No

If yes, please list reason and doctor seen:

_____

Has your child ever used a nebulizer or inhaler? Yes No

Has anyone in your family ever used a nebulizer or inhaler (mom, dad, sibling, grandparent, aunt, uncle) Yes No

Does your child own any of the following? (Please circle) Nebulizer Spacer Peak Flow meter

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Child's Past Medical History

	Yes	No
Any Hospitalizations?		
Any Surgeries?		
Any Emergency Room or Urgent Care Visits?		

Please answer all questions by checking Yes or No

Serious Injuries or accidents		
Surgeries		
Hospitalizations		
Chickenpox		
Frequent ear/sinus infections		
Sore throat/Strep		
Other infectious illness		
Allergies – please circle all that apply Animal dander dust mold pollens (trees, grass) Smoke Foods		
Is your child bothered by any of the following (cough, sneezing, short of breath, runny nose)? Please circle: Activity, Animals, Colds, Dust, Mold, Pollens, Smoke, Strong Odors, Weather Changes or Foods/other		
Asthma, bronchiolitis, wheezing, pneumonia, croup		
Heart problems or murmur		
Stomach pain/ Reflux		
Constipation		
Urinary problems – Pain, Infections		
Bed wetting (after 5 yrs of age)		
Eye Conditions/Glasses		
Ear problems – Hearing, Ringing		
Chronic skin problems – Acne, Eczema, etc		
Anemia or bleeding problem		
Blood Transfusion		
Frequent headaches		
ADD/ADHD or other attention problems		
Developmental Delays		
Seizures, or other neurological disorders		
Mental health concerns		
Orthopedic problems – Bone/musculoskeletal		
Diabetes or sugar problems		
Thyroid or other endocrine problems		
Female only – Has she started her menstrual cycle? When and at what age? How many days does it last? Painful?		
Use of drugs or alcohol		
Emotional problems – Anxiety, depression		
Any other significant problems		
Has your child ever received dental varnish		

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Family History:

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other
High Blood Pressure						
High Cholesterol						
Prolonged QT						
Early heart attach (under 50 yrs old)						
Sudden unexplained death						
Anemia						
Bleeding or clotting disorder						
Allergies						
Autoimmune disorder (RA, Lupus, etc)						
Cancer						
Developmental/genetic disease						
Diabetes						
Thyroid Disease						
Polycystic Ovarian Syndrome (PCOS)						
Ear tubes						
Deafness						
Stomach problems (Reflux, Ulcer, etc)						
Liver Disease						
Celiac disease						
ADD/ADHD						
Migraines						
Autism						
Seizures						
Mental Illness						
Drug/Alcohol abuse						
Asthma						
Tuberculosis						
Kidney problems						
Lazy eye or eye problems						
Hip dysplasia						
Other						