STEWART

Family Medicine & After-Hours

New Patient Registration

PEDIATRIC

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL & WILL BECOME PART OF YOUR MEDICAL RECORD.

HOW DID YOU HEAR ABOUT US?

DATE	NAME	DOB	SSN

CONTACT INFORMATION	
Phone 1	
Phone 2	
Email	
Mailing Address	

PLEASE CHECK THE APPROPRIATE BOXES

☐ Male ☐ Female

☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino

☐ White
☐ Black Or African American
☐ Asian
☐ Other:

PARENT / LEGAL GUARDIAN INFORMATION

☐ Mother ☐ Father ☐ Other:		☐ Mother ☐ Father ☐ Other:	
Name		Name	
DOB		DOB	
Cell Phone		Cell Phone	
Primary Email		Second Email	
Parents Are:	☐ Married ☐ Living Together ☐ Separated ☐ Divorced		
If Divorced, Who Is The Custodial Parent?			

INSURANCE INFORMATION

Primary		Secondary	
Policy Holder Name	Policy Holder DOB	Policy Holder Name	Policy Holder DOB

OTHER EMERGENCY CONTACT

List any other individuals who may bring your child for appointments or who are authorized to communicate with for medical information.

Name		Relationship		DOB	
Name		Relationship		DOB	

Does your child see a pediatrician for primary care needs, including well child visits and vaccinations?

☐ YES ☐ NO	Primary Care Provider		Office Phone	

Please list any other medical providers that your child sees.

Provider Name		Office		Phone	
Provider Name		Office		Phone	

I have reviewed all of the information on this form and agree that it is true and accurate. I understand that it is my responsibility to notify Stewart Family Medicine of any changes that may occur to the information I have given on this form.

Parent/Guardian Signature		**Printed Name**		**Date**	

STEWART

Family Medicine and After-Hours

Comprehensive New Patient Health History Questionnaire

PEDIATRIC

DATE	NAME	DOB	SSN

Main reason for today's visit?	

Please list any known ALLERGIES *or* intolerance to medications OR vaccinations.

MEDICATIONS

Please list all prescriptions and non-prescription medications. This includes vitamins, herbs, home remedies, or inhalers.

☐ Check box if you do not take any prescriptions or over the counter medications.

MEDICATION	DOSE	How many times per day?

PERSONAL MEDICAL & SOCIAL HISTORY

Does your child have now or have you had in the past any of the following conditions or procedures?

☐ Check box if you have no history of significant medical illnesses.

CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST
ADD			Autism			Type II Diabetes			High Blood Pressure			Pneumonia		
Adenoidectomy			Blood Clots			Eczema			High Cholesterol			RSV		
Alcohol/Drug Abuse			Blood Transfusion			Fractures			Hypothyroidism			Seizure Disorder		
Allergies			Cancer			GERD			Hyperthyroidism			Sickle Cell		
Anemia			Cerebral Palsy			Migraines			IBS			Stomach Ulcers		
Anxiety			Circumcision			Heart Murmur			Kidney Disease			Thalassemia		
Arrhythmia			Gallstones			Hepatitis			Kidney Stones			Tonsillectomy		
Appendectomy			Depression			Hernia			Obesity			UTI-Recurrent		
Asthma			Type I Diabetes			HIV			PE Tubes					

Are your child's immunizations up to date?	☐ YES ☐ NO ☐ UNKNOWN
Does your child have an IEP (Individualized Education Program?	☐ YES ☐ NO ☐ UNKNOWN

SECONDHAND SMOKE EXPOSURE

Does anyone smoke in the house or around your child?	☐ YES ☐ NO If YES, how often?	

FAMILY HISTORY

Please check off any known medical problems in your family and who is diagnosed with it.

☐ Check box if your family history is unknown.

✓	DISEASE	RELATION	✓	DISEASE	RELATION	✓	DISEASE	RELATION
	High Blood Pressure			Alzheimer's			Hip Fracture	
	High Cholesterol			Asthma			Thyroid Disease	
	Heart Attack			Autoimmune Disease			Kidney Disease	
	Diabetes			Bleeding/Clotting Disorder			Kidney Stones	
	Cancer			COPD			Macular Degeneration	
	Osteoporosis			Genetic Disorder			Stroke	
	Depression			Glaucoma			TIA	
	Alcohol or Drug Abuse			Heart Disease			Sudden Cardiac Death	

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For Office Use Only

Room #	Provider	Pharmacy

Height	Weight	BP	Pulse	Resp	Pulse Ox	Temp	HC	LMP	MA Initials

NOTES