The Pediatric Group
Louis J. Tesoro, MD
Helen M. Rose, MD
Paula G. Zollner, MD

New Patient Information Form

Name of Child:			DOB of child:
Date of Visit:	Here to see Dr.		
Insurance Company:			
Parent's Name:			DOB:
Occupation:			Work Phone:
Cell Phone:	Email:		
Parent's Name:			DOB:
Occupation:			Work Phone:
Cell Phone:	Email:		
Home Address:		Home Phone:	
Which phone # is primary?			
Other Children:			
Name:	DOB:	Adopted?	Delivery Type (Vag/C-sx):

Past, Family and Social History

Please indicate if child is adopted, and if so, from what country and at what age:		
Name of person completing form:		
Relationship to child:		

Name and DOB of child_____

Past History of Child (write "none" if applicable):	
Please list any chronic medical problems (asthma, allergies, diabetes, heart disease, etc):	
	1.
	2.
	3.
Please list any instances of hospitalization:	
	1.
	2.
	3.
Please list any surgery:	
	1.
	2.
	3.
Please list any significant trauma (such as concussions or fractures):	
	1.
	2.
	3.
Please list any significant childhood illnesses (chicken pox, measles, meningitis, reflux, birth defects, vision or hearing loss, etc):	
	1.
	2.
	3.
Please list any mental, emotional, developmental (i.e. attention span) issues:	
	1.
	2.
	3.
For female patients:	
	1. Date of first menstrual period:
	2. Date of most recent menstrual period:
	3. Any problems with periods:
Please list any allergies (medications, foods, environmental, other):	
	1.
	2.
	3.
Please list any medications the child is taking regularly (including birth control pills, inhalers, topical medicines, vitamins and supplements):	
	1.
	2.
	3.
Please list any specialists (cardiologist, dermatologist, etc.) that your child sees:	
	1.
	2.
	3.

Name and DOB of child_____

Family History:		
Is there a family history of:		
Disorders of the eyes other than the need for glasses (glaucoma, blindness, etc)?	No	Yes (list):
Disorders of the ears, nose or throat?	No	Yes (list):
Disorders of the respiratory system (asthma, cystic fibrosis, etc)?	No	Yes (list):
Disorders of the heart or cardiovascular system (heart attack, stroke, high blood pressure, etc)?	No	Yes (list; mention if present before age 50):
Disorders of the gastrointestinal tract (inflammatory bowel disease, ulcers, heartburn, hepatitis, disorders of the pancreas, etc)?	No	Yes (list):
Disorders of the urinary or genital tract (recurrent urine infections, kidney problems, endometriosis, etc)?	No	Yes (list):
Disorders of the musculo-skeletal system (arthritis, muscle problems or weakness, etc)?	No	Yes (list):
Disorders of the skin (cancer, staph infections, other skin lesions)?	No	Yes (list):
Disorders of the immune system?	No	Yes (list):
Disorders of the neurologic system (migraines, chronic headaches, seizures, dementia, developmental delay or disability, etc)?	No	Yes (list):
Disorders of the hematologic system (unuaual bruising or bleeding, leukemia, enlarged lymph nodes, etc)?	No	Yes (list):
Disorders of the endocrine system (diabetes, thyroid disorders, celiac disease)?	No	Yes (list):
Psychological disorders (anxiety, depression, phobias, ADHD, etc)?	No	Yes (list):
Cancers not mentioned elsewhere?	No	Yes (list):

Name and DOB of child_____

Other disorders not listed?	No	Yes (list):
Social History:		
Who lives at home (circle all that apply)?		
Mom	Dad	Sibs (how many)?
Grandparents	Other caretakers	Others
Please circle: Are parents single, married, separated, divorced, or widowed?		
If divorced, two households?		
Please circle: How would you describe your race (white, black, Hispanic, asian, other, would rather not say)?		
What language is spoken in your home?		
Please circle: How would you describe your religion (Christian, Jewish, Muslim, other, would rather not say)?		
Does anyone in the household smoke cigarettes, take drugs, or drink alcohol excessively?		
How old is your home?_____ yrs		
Do you have guns in your home?		
Do you have a pool?		
Are there pets in the home?		