SSMHealth WCH Washington County Hospital & Medical Group

New Patient - Pediatric History Form

Patient information

Today's Date ________________ Date of Birth ______________________

Name __________________________________ Age ______________________

Previous Primary Care Provider (if any) ____

Other Physicians involved in your care (List name and specialty)

______________________________________ ____

______________________________________ ____

What pharmacy do you use? ____

Intake

Reason for today's visit ____

Medication List (Please list medicine name, dose, frequency, and prescriber. Include over-the-counter medications)

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Allergies (Medication/Food - indicate reaction symptoms)

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Circle symptoms below if experienced in the last 1-2 weeks

Chills	Wheezing	Increased urination	Anxiety
Fatigue	Chest pain	Urinary frequency	Depression
Fever	Leg pain	Urinary incontinence	Insomnia
Malaise	Leg swelling	Urinary retention	Cold intolerance
Night sweats	Palpitations	Hair loss	Heat intolerance
Weight gain	Abdominal pain	Itching	Increased thirst
Weight loss	Blood in stools	Mole changes	Increased hunger
Ear pain/problems	Change in stools	Rash	Back pain
Eye pain/problems	Constipation	Skin lesion	Joint pain
Hearing loss	Diarrhea	Dizziness	Joint swelling
Nasal drainage	Heartburn	Extremity numbness	Muscle weakness
Sinus pressure	Loss of appetite	Extremity weakness	Neck pain
Sore throat	Nausea	Gait disturbance	Easy bruising
Vision changes	Vomiting	Headache	Easy bleeding
Chronic cough	Pain/burning with urination	Memory loss	Swollen glands
Cough	Blood in urine	Seizures	
Shortness of breath		Tremors	

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Histories

Medical History – please circle if you have a history of the following and write year of diagnosis

Allergies	Cardiac arrhythmia	Migraine headache	Heart attack
Anemia	COPD	Heart disease	Osteoporosis
Angina	Coronary artery disease	Heart valve disorder	Renal/kidney disease
Anxiety	Depression	Hepatitis/liver disease	Seizure disorder
Arthritis	Diabetes	Hypertension	Stroke
Asthma	Elevated cholesterol	Mental Health	Thyroid disease
Atrial fibrillation	Gallbladder disease	Prematurity	ADHD
Blood clots	GERD/acid reflux	Irritable bowel disease	Developmental Delay
Cancer			

Other /not listed above (please explain) ____

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Females ONLY – OB/GYN History

Age of first period ______________ Date of last menstrual period ________________

Are your periods regular? (Circle) Yes No

Number of pregnancies ________________ Number of deliveries ______________

Vaginal delivery/C-section _____________ Number of miscarriages/abortions ______________

Form of contraception used ______________________________

Date of last Pap test/what clinic ____________________________

Have you ever had an abnormal Pap? (Circle) Yes No

Surgical History/Medical Procedures – please circle and write year of surgery

Appendectomy	Carpal tunnel release	Knee replacement
Arthroscopy	Cataract removal	LASIK
Back surgery	Cholecystectomy (gallbladder)	ORIF (fracture repair)
Blood transfusion	Colostomy	Thyroidectomy
CABG (heart bypass)	D&C	Tonsillectomy/Adenoidectomy
Cardiac pacemaker	Gastric bypass	Circumcision
Murmur repair	Hernia repair	

Other/not listed above (please explain) ____

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Family History - Please list medical history for family members

Father ____
Mother ____
Siblings' ____
Paternal Grandmother ____
Paternal Grandfather ____
Maternal Grandmother ____
Maternal Grandfather ____

Social History

Are there smokers at home? Yes No Outside only? Yes No
Have you ever used tobacco? __________ Quit date ______________________
If no, are you exposed to second hand smoke? _____________________________
If yes, did you smoke or chew or both? _______________
How many years using tobacco? _____ How many cigarettes smoked per day? ______
Do you drink alcohol? (Circle) Yes No Formerly
How many drinks per week? ___________________________
Do you consume caffeine? (Circle) Yes No
Any recreational drug use? (Circle) Yes No
Are there any concerns in regards to the patient's diet, bowel, bladder, dental, vision or body image?
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Please bring your immunization record to your appointment.