PATIENT DEMOGRAPHICS

Patient Information:

- **Child's Name:**
- **Date of Birth:**
- **Gender:**
- **Preferred Pronouns:**
- **Parent/Guardian Name(s):**
- **Relationship to Child:**
- **Primary Contact Phone Number:**
- **Secondary Contact Phone Number:**
- **Email Address:**
- **Address:**
    - **Street:**
    - **City:**
    - **State:**
    - **ZIP Code:**
- **Emergency Contact (Other than Parent/Guardian):**
    - **Name:**
    - **Relationship:**
    - **Phone Number:**

Insurance Information:

- **Primary Insurance Company:**
- **Policy Holder's Name:**
- **Policy Number:**
- **Group Number:**
- **Secondary Insurance Company (if applicable):**
- **Policy Holder's Name:**
- **Policy Number:**
- **Group Number:**

Additional Information:

- **Preferred Pharmacy:**
    - **Pharmacy Name:**
    - **Phone Number:**
- **Preferred Language (if other than English):**
- **Other Information or Concerns:**

NEW PATIENT MEDICAL HISTORY

Name_____ Date of Birth_____

Primary Care Physician

Name:
Phone Number:

Pregnancy and Birth History

Pregnancy History:
Duration of pregnancy:
Prenatal care received:
Any complications during pregnancy:
Delivery/Birth History:
Type of delivery (vaginal, C-section):
Birth weight:
Apgar scores:
Any complications during delivery:

Developmental Milestones

Please indicate when your child achieved the following milestones:
Holding head up:
Rolling over:
Sitting:
Crawling:
Walking:
First words:
Other developmental milestones:

Past Medical History

Medical Conditions:
Any previous medical diagnoses or conditions:
Surgeries/Hospitalizations:
List any surgeries or hospitalizations your child has had:

Allergies

Allergies to medications, foods, insects, or environmental factors:

Medications

Please list any current medications your child is taking (prescription, over-the-counter, vitamins, supplements):

Immunization History

Please provide details of your child's immunizations, including delays in administration and/or reactions:

Family Medical History

Any significant medical conditions or hereditary diseases in the family:

Social History

Living Environment:
Who does the child live with?
Any recent changes in living situation?
Nutrition:
Describe typical diet and eating habits:
Physical Activity:
Amount and type of physical activity:
Sleep Patterns:
Typical sleep duration and any sleep disturbances:
Screen Time:
Amount of time spent on screens (TV, computer, tablet, smartphone):

Behavioral and Developmental History

Any concerns or observations regarding behavior, learning, or development:

Environmental Exposures

Any exposure to tobacco smoke, lead, or other environmental toxins:

Review of Systems

Please indicate if your child has experienced any of the following symptoms or issues:

General: Fever, weight loss/gain, fatigue. ☐
Skin: Rashes, itching, lesions. ☐
Head/Eyes/Ears/Nose/Throat: Headaches, vision/hearing changes, nasal congestion, sore throat. ☐
Cardiovascular: Chest pain, palpitations. ☐
Respiratory: Cough, wheezing, shortness of breath. ☐
Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation. ☐
Genitourinary: Painful urination, frequency, urgency, incontinence. ☐
Musculoskeletal: Joint pain, stiffness, swelling. ☐
Neurological: Seizures, numbness/tingling, weakness. ☐
Additional Information:

I certify that the information provided on this form is accurate to the best of my knowledge.

X _____

Parent/Guardian Signature