Patient Label

C0390-0251

Pediatric New Patient Form
C0390-10000-11-0251-MR (Rev. 01/11)

NAME: ______________________ DATE: ____ / ____ / ____

MOTHER'S NAME: ______________________ DOB: ____ / ____ / ____

FATHER'S NAME: ______________________ AGE: ____________

SIBLING(S)/AGE(S): ______________________

Special cultural beliefs that might affect child's healthcare ______________________

HISTORY:

Complications w/pregnancy ______________

Birth: ❑ vag ❑ C-section

Birthweight: __________ Birthlength: __________

Special diet: ❑ yes ❑ no ______________

Medications: ______________

Drug/medication allergy: ❑ no ❑ yes: __________

FAMILY HISTORY

- ❑ Stroke/heart disease
- ❑ Cystic fibrosis
- ❑ Sickle cell disease
- ❑ Diabetes
- ❑ Hip problems
- ❑ High blood pressure
- ❑ Scoliosis
- ❑ Melanoma/skin cancer
- ❑ Recurrent ear infections
- ❑ SIDS/Early infancy death
- ❑ TB
- ❑ Kidney disease
- ❑ Anemia/bleeding
- ❑ Deafness
- ❑ Seizures
- ❑ Lazy eye
- ❑ Allergies/asthma/eczema
- ❑ Attention deficit disorder

Surgeries: (Age, Diagnosis): ______________________

Hospitalizations (Age, Diagnosis): ______________________

Any problems at school: ______________________

Other problems: ______________________

IMMUNIZATION DATES:							
DPT 1	___/___/___	OPV 1	___/___/___	DPT/HIB 1	___/___/___	HIB 1	___/___/___
DPT 2	___/___/___	OPV 2	___/___/___	DPT/HIB 2	___/___/___	HIB 2	___/___/___
DPT 3	___/___/___	OPV 3	___/___/___	DPT/HIB 3	___/___/___	HIB 3	___/___/___
DPT 4	___/___/___	OPV 4	___/___/___	DPT/HIB 4	___/___/___	HIB 4	___/___/___
DPT 5	___/___/___	MMR 1	___/___/___	DT	___/___/___	HEPB 1	___/___/___
		MMR 2	___/___/___	TB	___/___/___	HEPB 2	___/___/___
		Chicken Pox	___/___/___	TB	___/___/___	HEPB 3	___/___/___

DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR CHILD'S HEALTH OR DEVELOPMENT?

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TO BE COMPLETED BY THE NURSE

Welcome letter provided and discussed	❑ YES	❑ NO
State immunization program explained	❑ YES	❑ NO
Consent form for immunization obtained	❑ YES	❑ NO
Immunization records verified/booklet given	❑ YES	❑ NO
Will get immunizations at the Health Department	❑ YES	❑ NO

Needs: ____

F/U referrals needed: ____

Support system in place: ____

Equipment needed: ____

Additional comments: ____

Nurse signature: ______________________________ Date: ______ / ______ / ______