# New Patient

# Medical History

Healthy Children Pediatrics LLC
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**Name**:_____**Date of Birth**:_____**Date**: _____

Immunizations Up to Date ? : ▭Yes ▭No

Allergies ? If yes, to what? _____

Receive any type of medical care elsewear? If yes, explain. _____

On or previously was on any medication? (If yes , which ?) : _____

Past Medical History
(If yes to any explain in detail)

Serious medical conditions? Yes ▭ No ▭ : _____

Surgeries ? Yes ▭ No ▭ : _____

Hospitalizations? Yes ▭ No▭ : _____
Disease? Yes ▭ No ▭
Frequent ear infections or sinus infections? Yes ▭ No ▭: _____
Animals in the home? Yes ▭ No ▭ What kind ?_____
Asthma? Yes ▭ No ▭ : _____
Pneumonia , Bronchitis, Croup? Yes ▭ No ▭ : _____
Heart Issues? Yes ▭ No ▭ : _____
Bladder or Kidney Infections? Yes ▭ No ▭ : _____
Bedwetting after age 5? Yes ▭ No ▭ : _____
Eye conditions? (Please select yes if your child wears glasses/contacts) : _____
Problems with hearing ? Yes ▭ No ▭ : _____
Chronic or recurrent skin conditions (acne,eczema, etc.) : _____
Anemia? Yes ▭ No ▭ : _____
Diabetes ? Yes ▭ No ▭: _____
Frequent headaches ? Yes ▭ No ▭ : _____
Seizures ? Yes ▭ No ▭ : _____
Use of alcohol or drugs ? Yes ▭ No ▭: _____
Depression? Yes ▭ No ▭ : _____
Current Smoker? Yes ▭ No▭ :_____

If female, have menstrual periods started?When? Yes ▭ No ▭ : _____

Other ?, _____