GEORGETOWN PEDIATRICS. P.C,

New Patient Medical History		
Patient's Name:	Today's Date:	Called by:
Birth Information: Date:	Wt.:	Length: Sex: (M) (F)
Neonatal Problems:		
Jaundice (Y) (N) Required Treatment (Y) (N) if yes, explain:		
Breathing Problem (Y) (N) Required Oxygen (Y) (N) Infection (Y) (N) Required Antibiotics (Y) (N) If yes, explain:		
Other problems related to birth?		
Patient lives with: (Give name and relationship)		
Parents are: Married: ☐ Divorced: ☐ Separated: ☐ Other: ☐		
Patient attends school or daycare facility?		
Approximate age of housing where patient resides? (Considered for possible lead exposure)		
Any medications currently or frequently used: (Y) (N) if yes, please list below		
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Any hospitalizations or surgeries: (Y) (N) if yes, please list		
Any known allergies: (Y) (N) if yes, please list		
Any adverse reaction to medications: (Y) (N) if yes, please list		
Any adverse reaction to immunizations: (Y) (N) if yes, please list		
Family History: Is patient adopted? (Y)(N) (If yes, please complete as much information below as know)		
Mother's birth year:	Mother's height:	
Father's birth year:	Father's height:	
Brother's birth year:	Brother's height:	
Sister's birth year:	Sister's height:	

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Please fill in the appropriate column if either the patient or the family member has had a history of any of the following medical problems:

Medical Diagnosis	**Y** ✓	**N** ✓	**Patient** (Age of Diagnosis)	**Family** (Member and *Age of Diagnosis)*
Addictions (drug, alcohol, tobacco)				
Anemia or Bleeding Disorders				
Asthma, breathing problems				
Behavioral, psychological				
Cancer				
Chronic Skin Disorders				
Cystic Fibrosis				
Deafness or Hearing Disorder				
Diabetes				
Digestive Disorders				
Fracture or Bone/Joint Disorder				
Frequent or severe infections				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Learning Disorders				
Liver Disease				
Mental Retardation				
Migraine				
Seizures				
Significant Heart Murmur				
Thyroid Disease				
Tuberculosis				
Unexplained Death				
Urinary Tract Infections				
Visual Disturbances				

Please list any other problems or concerns the doctor should be aware of:

_____

_____

Parent or Guardian Signature _____ **Date** _____

Reviewed by: _____ **Date** _____