SUMMIT PEDIATRICS NEW PATIENT HISTORY

Patient Name _____DOB_____

Medical History

1. Was your child full term or preterm (4 or more weeks early)?
2. Were there any problems during your pregnancy? Did you take any medications during your pregnancy/labor/delivery?
3. Did your child have any problems right after birth?
4. Has your child ever stayed overnight in the hospital? If yes, when and for what problem
5. Has your child ever had an operation? If yes, what was it and when?
   Anesthesia problems?
6. Has your child taken any long-term medications (more than 2 weeks)? If yes, what? How long was the medicine continued?
7. Does your child have any allergies? Medication_____Other_____
8. Is your child seeing any Specialists, if so who_____
9. Are your child's immunizations up to date? Please provide us with your child's immunization record.

If your child has ever had any of the following problems, please **circle** the problem and write how old they were when it started or when they had it:

	AGE		**AGE**
Asthma		Hearing Problems	
Bedwetting/daytime accidents		Frequent headaches	
Bladder or kidney infection		Any heart problem or heart murmur	
Broken bones		Learning problems	
Chicken pox		Problems with eyes or vision	
Concussion		Scoliosis/back trouble	
Depression		Seizures	
Diabetes		Skin problems	
Elevated Lead Levels		Second-hand smoke exposure	
Frequent ear infections		Speech difficulties	
Bleeding disorder		Behavior/Developmental Problems	

PLEASE CONTINUE ON BACK

Family Health Information

Please **circle** the disease if anyone in your child's family (parents, grandparents, brother/sister, aunts, uncles, or cousins) has these diseases and write your child's relationship to that person:

	Relationship		Relationship
Alcohol abuse		High blood pressure	
Asthma		Kidney disease	
Cancer		Learning problems	
High cholesterol		Mental illness, suicide, trouble with nerves	
Deafness		Seizures	
Adult onset diabetes		Stroke	
Childhood onset diabetes		Sudden unexplained death	
Drug abuse		Thyroid disease	
Heart Attack (less than 65 yrs old)		Other diseases	
Bleeding Disorders			

Family Information

With whom does your child live? (Mom, Dad, brothers and sisters, other people?) If split custody, please describe the arrangement.

Have you had any family problems?

Form completed by_____relationship_____