

NEW PATIENT FORM PEDIATRIC MALE DATE _____

NAME _____ DATE OF BIRTH _____

Medication allergies and type of reaction: _____

Current Medications and dosage: _____

Does the patient have any diseases or health problems such as:

Allergies _____ Asthma ___ ADHD _____ Eczema _____

Anemia ___ Recurrent Urinary Tract Infections _____

Epilepsy ___ Heart Murmur ___ Cancer _____ Frequent Ear Infections _____

Other _____

Surgical History: Has the patient ever had: (please list dates)

Circumcision: _____ Fracture (broken bone) Repair _____ Hernia Repair _____

Ear Tubes _____ Appendix removed _____ Tonsils and/or Adenoids removed _____

Other Surgeries: _____

Delivery or newborn problems:

___ prolonged labor ___ deformities ___ Oxygen

___ Breech ___ Injuries ___ Forceps used

___ Breathing difficulty ___ Gestational Diabetes

___ Caesarean ___ Jaundice ___ Toxemia

_____ Newborn hospital stay

Use (during pregnancy) of ___ tobacco ___ alcohol ___ drugs

Has the patient ever had: Scarlet fever _____ Chicken Pox _____

Colic _____ Measles _____ Mumps _____ Rheumatic fever _____

Has the patient ever been hospitalized? If yes, please explain: _____

FAMILY HISTORY: (Includes parents, immediate grandparents, siblings, immediate aunts/uncles) Please state who and their age.

Has anyone ever been diagnosed with:

High Blood Pressure _____	High Cholesterol _____
Heart Attack _____	Heart Failure _____
Diabetes _____	Thyroid Problems _____
Asthma _____	Cystic Fibrosis _____
Crohn's Disease _____	Colon Polyps _____ Reflux Disease _____
Irritable Bowel Syndrome _____	Liver Problems _____ Kidney failure _____
Urinary Problems _____	Kidney Stones _____
Fibromyalgia _____	Osteoarthritis _____ Osteoporosis _____
Rheumatoid Arthritis _____	Seizures _____ Down's Syndrome _____
Multiple Sclerosis _____	Blood Disorders _____ Alcoholism _____
Depression _____	Anxiety _____
Bipolar Disorder _____	
Cancer _____	
Other _____	

Parent's Marital Status: _____

Number of members in the household: _____

Is the patient in school/daycare? If so, please state where and what grade. _____

Does the patient participate in any clubs or teams? _____

Is the patient exposed to tobacco smoke? _____

Please bring the following with you to your appointment:

- ✓ **Immunization Record**
- ✓ **Current medications**
- ✓ **New Patient Form**
- ✓ **Pediatric Authorization Form**

PEDIATRIC TREATMENT AUTHORIZATION

I, _____, do hereby authorize the physicians of North State Medical Group to treat my child, _____, in the event of an emergency, whereby I am unable to be contacted in a reasonable amount of time. This authorization will also cover care of my child in the event that I am out of town, or otherwise unable to be contacted, and my child is brought to the medical office in the care of a delegated family member or friend.

Furthermore, I understand that this authorization will remain in effect until such is this revoked in writing.

Authorized Signature _____

Date _____