New Pediatric Patient Form

North State Medical Group

Birth Sex: Male / Female

Name: _____

Date: _____

Medication allergies and type of reaction: _____

Current Medications and dosage: _____

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

Allergies _____ Asthma _____ ADHD _____ Diabetes _____
Eczema _____ Anemia _____ Obesity _____ Epilepsy _____
Heart Murmur _____ Cancer _____ Frequent Ear Infections _____
Other _____

Gynecological History:

Age of onset of menstrual cycles: _____
Any gynelogical problems: _____
Recurrent Urinary Tract infections _____ Recurrent Yeast Infections: _____

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

Fracture (broken bone) Repair _____ Hernia Repair _____ Ear Tubes _____
Appendix Removal _____ Tonsils and/or Adenoids removed _____
Other Surgeries: _____

Delivery of Newborn Problems:

Prolonger labor _____ Deformities _____ Oxygen _____ Breech _____ Injuries _____ Forceps Used _____
Breathing Difficulty _____ Gestational Diabetes _____ Caesarean _____ Jaundice _____ Toxemia _____
Feeding Problems _____ 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: (Included parents, immediate grandparents, siblings, immediate aunts/uncles) Please state who and their age.

Has anyone ever been diagnosed with:

High Blood Pressure _____
Heart Attack _____
Diabetes _____
Asthma _____
Crohn's Disease _____
Irritable Bowel Syndrome _____
Liver Problems _____
Urinary Problems _____
Fibromyalgia _____
Osteoporosis _____
Seizures _____
Mental Retardation _____
Blood Disorders _____
Depression _____
Bipolar Disorder _____

High Cholesterol _____
Heart Failure _____
Thyroid Problems _____
Cystic Fibrosis _____
Color Polyps _____
Reflux Disease _____
Kidney Failure _____
Kidney Stones _____
Osteoarthritis _____
Rheumatoid Arthritis _____
Down's Syndrome _____
Multiple Sclerosis _____
Alcoholism _____
Anxiety _____
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 ember or friend.

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

Authorized Signature _____
Date _____