DATE _____

NAME _____ **AGE** _____ **Years**_____ **Months**_____

DATE OF BIRTH _____ **AGE OF PARENTS: MOTHER** _____ **FATHER** _____

REFERRING/CONSULTING PHYSICIAN _____

PAST MEDICAL HISTORY

Drug Allergies _____ Immunizations up to date? _____ yes _____ no
Current Medications _____ Previous Surgery_____
Medical Illnesses & Hospitalizations _____
_____
_____
_____
Chronic Conditions _____
Have you seen other medical specialists? _____ Pulmonary ___ Allergist _____ Cardiology ___ Gastroenterology
_____ Surgery ___ Other _____

DEVELOPMENTAL HISTORY

Length of pregnancy ____ Delivery:Vaginal ___ Caesarean_____ Breech ____ Breast Fed ____ Bottle Fed _____How Long?_____
Birth Weight _____ Length of hospital stay at birth _____ Ventilator Use _____ Apnea Monitor _____
Problems during Neonatal period _____
Age at sitting _____ Age rolling over back to front _____ Age at speech _____ Age at walking _____

SOCIAL HISTORY

Patient lives with _____ Adopted _____ yes _____ no Brothers _____ Sisters _____
Is the Child in Day Care? No _____ Yes _____ Current Grade in School _____ School Problems _____
Learning or Behavioral Issues _____
_____
_____
_____
_____
_____

FAMILY HISTORY (Write Yes or No and Indicate Relationship)

Diabetes _____
Lung Disease / TB _____
Cancer _____
Heart Disease / Stroke _____
Hypertension _____
Thyroid Disorder _____

Kidney / Urinary Disease _____
Allergies / Asthma _____
Blood Dyscrasias _____
Birth Defects _____
Cystic Fibrosis _____

Emotional Illness _____
Mental Retardation _____
Seizures / Epilepsy_____
Substance Abuse _____
Other _____

Joe DiMaggio Children's Hospital
Memorial Healthcare System
DIVISION OF PEDIATRIC SPECIALTY CENTER
NEW PATIENT HISTORY

PATIENT/LABEL

2310-01274 (REV. 10/02)

MEDICAL INFORMATION (If circled yes, please also CIRCLE all conditions that apply)

Yes / No Unexplained weight gain or loss?
Yes / No Recent fever? (above 100 degrees)
Yes / No Eczema, itching, rashes, or large birth marks?
Yes / No Eye surgery, glasses or contact lens?
Yes / No Recurrent infection, congestion, or discharge in or from ears/nose/throat/mouth?
Yes / No Heart murmurs, shortness of breath, high blood pressure?
Yes / No Asthma, chest pain, recurrent cough?
Yes / No Feeding problems, diarrhea, constipation, vomiting?
Yes / No Kidney or bladder infection, pain with urination, inability to control urine?
Yes / No Other joint pains,fractures? (other than what you are being seen for today)
Yes / No Seizures, head trauma, delayed age for walking/talking, attention deficit disorders, learning issues at school?
Yes / No Depression, behavioral problems,addiction?
Yes / No Any known problems with thyroid, growth hormone, diabetes?
Yes / No Bleeding problems, easy bruising, frequent nose bleeds, low blood count, sickle cell disease?
Yes / No Recurrent unexplained arm or leg swelling, bumps or knots under the arm or in groin?
Yes / No Environmental allergies, food allergies, sensitivity to costume jewelry or balloons?

IF OVER AGE 12

Do you use non prescription drugs? Yes / No
If yes, what kind? _____

IF OVER AGE 14

Do you drink alcohol? Yes / No
Do you use tobacco? Yes / No
(smoking or chewing)

MENSTRUAL HISTORY(females over age 10)

Have you started your periods? Yes / No
If you have started your periods, how long ago?_____
When was your last period?_____ reg_____ Irregular _____
Pain/Cramps _____ Days of Flow _____
Is there a possibility you are pregnant? Yes / No
Birth Control Method _____

BARRIERS WHICH MAY IMPACT NURSING CARE / LEARNING:	
Do you have any **cultural concerns** that you would like to share with us? _____ No _____ Yes If yes, specify:	Is there an **inability to read or write?** _____ No _____ Yes If yes, specify:
Do you have any **religious concerns** that you would like to share with us? (i.e. blood transfusions) _____ No _____ Yes If yes, specify:	Do you have any **emotional or psychological concerns** that you would like to share with us? _____ No _____ Yes If yes, specify:
Do you have a **language barrier**? _____ No _____ Yes If yes, specify:	Do you have any **financial concerns** that you would like to share with us? _____ No _____ Yes If yes, specify:
Do you have any **physical, visual, hearing, speech or learning** impairments? _____ No _____ Yes If yes, specify:	**Other concerns** that you feel may affect the care of your child? _____ No _____ Yes If yes, specify:

Reviewed above Information:

_____ _____
Physician Signature / Print Name Date

_____ _____
A.R.N.P. Signature / Print Name Date

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