# MEADE COUNTY PEDIATRICS
# NEW PATIENT INFORMATION

Date: _____

E-mail Address:_____

Patient's Full Name:_____ Nickname:_____
Patient's Primary Address:_____
Birth Date:_____SSN:_____Sex:_____OB Doctor:_____

Father's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Address:_____
No. and street City State Zip
Father's Employment:_____Work Phone:_____

Mother's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Address:_____
No. and street City State Zip
Mother's Employment:_____Work Phone:_____

Legal Custodian's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Custodian's Address:_____
No. and street City State Zip
Custodian's Employment:_____Work Phone:_____

**Primary Pharmacy:** _____

Address: _____

Telephone: _____

**Emergency Contacts**

(Please list TWO who live outside your home.)

1st Contact Name:_____Relation:_____
Home Phone:_____Cell Phone:_____
Address:_____
No. and Street City State Zip
2nd Contact Name:_____Relation:_____
Home Phone:_____Cell Phone:_____
Address:_____
No. and Street City State Zip

I. **Prenatal History:**

Any problems with pregnancy (if so, please explain)?

_____

What was the birth weight? _____

Did your baby have any problems in the hospital? (eg. Jaundice, infection, other) _____

Name of hospital where child was born._____

II. **Past Medical History:**

Who was your child's previous physician? _____

Medications taken regularly (please list) _____

Allergies to medications, food, insect bites (please list) _____

Any chronic medical conditions? (please list) _____

Hospitalizations? (please list) _____

Surgeries? (please list) _____

Are Immunizations up to date? Yes No Where are those records located?_____

III. **Family History:**

Are both parents in good health? Yes No Comments _____

Does your child's parent, grandparent, brother, or sister have any of the following? Please circle

Anemia Asthma Allergies Diabetes High blood pressure Heart trouble

Seizures/ Congenital Malformations or Syndromes Mental Illness Cancer

Does anyone in your home smoke? Yes No

IV. **Review of Systems:**

Please circle any of the following that apply to the patient:

Hearing problems Vision problems Fatigue Eczema, hives, or skin condition

Frequent ear infections Wheeze/Asthma problems Heart murmur or heart problem

Seizure Urine or kidney problems Psychological problems Anemia

Muscle or Joint problems Developmental issues

Has your child had any other medical problems? Please list _____