THOMASVILLE PEDIATRICS
ARCHDALE-TRINITY PEDIATRICS
WELL-CHILD CLINIC & MIDWAY PEDIATRICS

New Patient History Form

Patient Name: _____

Date of Birth: _____ Your Relationship to Patient: _____

Has your child been seen at another medical facility before today's visit?

☐ No ☐ Yes Date: _____

Location: _____

Reason: _____

Preferred Pharmacy: _____ Location: _____

Medications the patient is currently taking (if more than four inform nurse):

☐ Not currently taking medications

_____dosage_____ _____dosage_____

_____dosage_____ _____dosage_____

Does the patient have any allergies (if allergic to more than two things, please inform nurse): ☐ Yes ☐ No

Allergic to: _____ What happens if they are exposed? _____

Allergic to: _____ What happens if they are exposed? _____

Birth History for patient less than 2 months old (if known):

Was the pregnancy normal: ☐ Yes ☐ No

Was the labor and delivery normal: ☐ Yes ☐ No

Were there complications in the nursery: ☐ Yes ☐ No

Was the child delivered via C-Section? ☐ Yes ☐ No

Was the child full term (40 weeks): ☐ Yes ☐ No

If less than full term, please indicate how many weeks the mother was before delivery: _____ weeks

Child's birth weight/length: ___lbs / _____oz / _____in

Does the child have any chronic illnesses (example: Diabetes, asthma, seizures..etc) ☐ Yes ☐ No (if yes, please indicate) _____

Social History:

If patient is over 13, do they smoke?

☐ Yes ☐ No ☐ Unknown

Are there any smokers in the home: ☐ Yes ☐ No

Are there pets in the home: ☐ Yes ☐ No

If Yes, what kind of pet? _____

Have any of the patient's family members been diagnosed with the following (if known):

	Mom:	Dad:	Sibling:	Mom's Parents:	Dad's Parents:
Allergies	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Convulsions / Seizures	☐	☐	☐	☐	☐
Deafness	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

Thank you for filling out this information!

In order to keep the patient's records up-to-day, you may be asked to fill this form out at each visit.

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