New Patient Information
(Child Age 0-12)

Name:_____DOB:_____/_____/_____Date:_____/_____/___

Preferred name: _____ School Attending: _____ Current Grade: _____

Person providing information /relationship:_____

List those who are living at home with the child(parents, siblings, etc.): _____

_____

1. List the medicines child is currently taking:

Medication/dose/times per day	Medication/dose/times per day	Medication/dose/times per day

Preferred Pharmacy: _____

List any allergies child has and describe reaction:

Check if child has or has had any of the following illnesses:

	Rheumatic Fever		Pneumonia		Cancer		Tuberculosis
	Heart Trouble		Emphysema		Menstrual Problems		Glaucoma
	High Blood Pressure		Ulcers		Stroke		Colitis
	Asthma		Hepatitis		Epilepsy / Convulsions		Blood Clots
	Hay Fever		Urinary Tract Problems		Anxiety / Depression		H.I.V.
	Diabetes		Thyroid Problems		Skin Problems		
	Anemia		Arthritis		Other (specify)		

2. Surgery, Injury, or Reason for hospitalization | **Year or Age** | **Hospital** | **Doctor's Name**

3. Family Medical History

Check if any of these diseases have occurred in blood relatives. List those who have had it.

	Diabetes			Epilepsy			Anxiety	
	High Blood Pressure			Arthritis			Depression	
	Anemia			Allergy			Cancer (type?)	
	Bleeding Disorder			Asthma				
	Thyroid Disease			Stroke			Heart Trouble	
	Tuberculosis			Suicide			Other (list)	

List any close relatives who have died and the cause of death:

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NEW PATIENT INFORMATION (CHILD) Cont.

4. **Birth and Infant History:**
   List any problems during or before birth: _____
   _____
   Birth weight: _____ Number of days until baby went home from hospital: _____
   Premature? _____ If yes, by how much? _____
   Jaundice at birth? _____ Breast Fed? _____ If yes, to what age? _____ Bottle Fed? _____
   If yes, name of formula: _____

5. **Medical Providers:**
   Please list all medical providers the child has seen in the last 5 years and why they saw them:

Name:	Contact:	Reason:

6. **Oral History:**
   Describe child's overall oral health: _____
   Bridges/implants? _____ Who is the child's dental provider? _____
   Date of last visit: _____

7. **Mental Health History:**
   Does child see a mental health professional? _____ If yes, Who? _____
   Why? _____

8. **Vision History:**
   Does child see an eye doctor? _____ If yes, Who? _____
   Date of last visit: _____

9. **Immunization History:**
   **Please provide us with a current immunization record for child.

   Did child receive any immunizations in a state other than Idaho? _____

10. **Is there anything else you would like your doctor to know?**
    _____
    _____
    _____
    _____

    Parent/Guardian Signature: _____ Date: _____