



NEW PATIENT MEDICAL HISTORY

TODAY'S DATE: _____



PATIENT'S NAME		DATE OF BIRTH		PHONE	
PREVIOUS PEDIATRICIAN		OFFICE PHONE		ADDRESS	
OTHER HOUSEHOLD MEMBERS					
NAME		DOB	RELATIONSHIP	OCCUPATION	
PAST MEDICAL HISTORY			SIGNIFICANT FAMILY HISTORY		
SURGERIES			BIRTH HISTORY (CIRCLE IF APPLICABLE)		
			TERM	UNCOMPLICATED	
			OTHER (PLEASE EXPLAIN):		
HOSPITALIZATIONS					
ALLERGIES AND SENSITIVITIES			ADVERSE MEDICATION REACTIONS		
REGULARLY SEEN SPECIALISTS			APPROXIMATE DATE OF LAST SPECIALIST VISIT		
ONGOING MEDICAL CONDITIONS			ONGOING MEDICATIONS		
	BEGAN	ENDED		BEGAN	ENDED