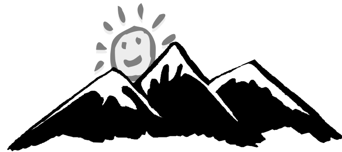

Sierra Pediatrics

New Patient Medical History

Who currently lives in your home?	Relationship to Child	Age
______________________	______________	________
______________________	______________	________
______________________	______________	________
______________________	______________	________
______________________	______________	________

Pregnancy / Child's Birth History

If Yes, Please Explain

During pregnancy with this child, were there any complications? . . . . ☐ No ☐ Yes
Were any medicines / illicit drugs taken during the pregnancy? . . . . ☐ No ☐ Yes
Did mom smoke during pregnancy?. . . . . ☐ No ☐ Yes
Did mom have any abnormal prenatal labs? . . . . ☐ No ☐ Yes
Was your child born premature (< 37 wks) or post term (> 42 wks)? . . . . ☐ No ☐ Yes
Were there any complications during delivery? . . . . ☐ No ☐ Yes
Was your child born by C-section? . . . . ☐ No ☐ Yes
Birth weight = __________
Were there any problems with your child after birth? . . . . ☐ No ☐ Yes

Your Child's Health History

If Yes, Please Explain

Is your child currently on any medications? . . . . ☐ No ☐ Yes
Has your child ever had a reaction to any medications? . . . . ☐ No ☐ Yes
Has your child had any of the following:

- Asthma? . . . . ☐ No ☐ Yes
- Allergies? . . . . ☐ No ☐ Yes
- Frequent Ear Infections? . . . . ☐ No ☐ Yes
- Pneumonia? . . . . ☐ No ☐ Yes
- Recurrent Strep Throat? . . . . ☐ No ☐ Yes
- Chickenpox? . . . . ☐ No ☐ Yes
- Bladder / Kidney Infection? . . . . ☐ No ☐ Yes
- Kidney Disease? . . . . ☐ No ☐ Yes
- Seizures? . . . . ☐ No ☐ Yes
- Heart Disease? . . . . ☐ No ☐ Yes
- Bleeding Disorder? . . . . ☐ No ☐ Yes

Does your child have any other chronic or serious illnesses? . . . . ☐ No ☐ Yes
Has your child ever been hospitalized? . . . . ☐ No ☐ Yes
Has your child ever had surgery? . . . . ☐ No ☐ Yes
Has your child ever had any major trauma / injury? . . . . ☐ No ☐ Yes
Does your child / family use alternative medicine? . . . . ☐ No ☐ Yes

Your Child's Nutrition History

If Yes, Please Explain

Does your child have any feeding / eating difficulties? . . . . ☐ No ☐ Yes
Has your child ever been put on a special diet? . . . . ☐ No ☐ Yes
Does your child have a weight problem? . . . . ☐ No ☐ Yes

(OVER)

Your Child's Family History

If Yes, Please Explain

Has any blood relative on either side of the family had:

Condition	No	Yes
Allergies?	☐ No	☐ Yes
Asthma?	☐ No	☐ Yes
Lung Disease?	☐ No	☐ Yes
Heart Disease / Stroke?	☐ No	☐ Yes
Sudden Death prior to age 55? (Parents / Grandparents Only)	☐ No	☐ Yes
High Blood Pressure?	☐ No	☐ Yes
High Cholesterol? (Parents Only)	☐ No	☐ Yes
Seizures or Epilepsy?	☐ No	☐ Yes
Other Neurologic Diseases?	☐ No	☐ Yes
Diabetes?	☐ No	☐ Yes
Thyroid Problems?	☐ No	☐ Yes
Digestive Problems (Reflux, Ulcers, etc)?	☐ No	☐ Yes
Kidney / Urinary Tract / Genital Disease?	☐ No	☐ Yes
Cancer / Blood Disorder?	☐ No	☐ Yes
Immune Deficiency?	☐ No	☐ Yes
Skin / Muscle / Skeletal Disorder?	☐ No	☐ Yes
Depression / Mental Illness?	☐ No	☐ Yes
Physical / Sexual abuse?	☐ No	☐ Yes
Alcoholism / Drug abuse?	☐ No	☐ Yes
Other Disorders and / or Diseases?	☐ No	☐ Yes

Your Child's Environmental / Social History

If Yes, Please Explain

Question	No	Yes
Does your child attend daycare?	☐ No	☐ Yes
Are there any pets in the home?	☐ No	☐ Yes
Are there any smokers that live in the house?	☐ No	☐ Yes
Are there firearms / handguns in your home?	☐ No	☐ Yes
Is anyone in your family getting hit, punched, or abused?	☐ No	☐ Yes
Do you have any questions / concerns about child proofing your home?	☐ No	☐ Yes
Are there any disabled / malfunctioning smoke detectors in your home?	☐ No	☐ Yes
Do you have any questions / concerns about infant / child car seat use?	☐ No	☐ Yes
Does your child drink water that is pumped from a well on your property?	☐ No	☐ Yes

Your Child's Developmental / Education History

How old was your child when he / she (circle one age range for each question if applicable):

Milestone				
Sat alone?	0-4 mo.	4-8 mo.	8-12 mo.	over 12 mo.
Walked without holding on?	0-10 mo.	10-18 mo.	18-24 mo.	over 2 yrs.
Said first words?	0-10 mo.	10-15 mo.	15-24 mo.	over 2 yrs.
Talked with 2-3 words together?	18-24 mo.	2-3 yrs.	3-4 yrs.	over 4 yrs.
Was fully toilet trained?	2-3 yrs.	3-5 yrs.	5-6 yrs.	over 6 yrs.
Stayed dry through the night?	2-4 yrs.	4-6 yrs.	6-8 yrs.	over 8 yrs.

If your child attends school please answer the following questions: **If Yes, Please Explain**

Question	No	Yes
Does your child have any difficulties with:	☐ No	☐ Yes
Reading?	☐ No	☐ Yes
Writing?	☐ No	☐ Yes
Speech?	☐ No	☐ Yes
Mathematics?	☐ No	☐ Yes
Coordination?	☐ No	☐ Yes
Has your child ever been in a special education program?	☐ No	☐ Yes
Has your child ever had behavior or discipline problems in school?		

Thank you for completing this form! ☺