SUNSHINE VALLEY
PEDIATRICS

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NEW PATIENT INFORMATION SHEET

AGES 1 TO 18 YEARS

Please complete this form carefully and thoroughly. If there are any questions you do not understand, please ask a staff member or physician for assistance. If you would like to inform the doctor of any additional information, please make sure to note the information on this form.

Patient's name:	Patient's Date of birth:
Name of parent or person completing this form:	
How were you referred to this office?	

PREGNANCY AND BIRTH

Mother's age at time of birth:		
Did mother have any illness during pregnancy? If Yes, please explain.	Y	N
Did mother take any medications other than vitamins/iron? If Yes, please explain.	Y	N
Was the baby delivered on time? If not, please explain.	Y	N
Did the baby have trouble starting to breathe?	Y	N
What was baby's birth weight?		
Did baby have any problems while in the hospital? If yes, please explain.	Y	N
Please add any additional information you wish to provide about the pregnancy and birth.		

PATIENT'S MEDICAL HISTORY

Date of child's last medical checkup: Doctor's Name:		
Date of child's last dental checkup: Dentist's Name:		
Has child had a reaction to any immunization? If yes, please list each immunization and what the reaction was.	Y	N
Has child been hospitalized for anything since birth? If yes, please explain.	Y	N
Has child had any surgeries or operations? If yes, please explain.	Y	N

Is your child on any medications today? If yes, please list medications and how long child has been on them.	Y	N
Does your child take medication regularly? If yes, please list medications and how long child has been on them.	Y	N
Please add any additional information you wish to provide about child's medical history.		

PATIENT AND FAMILY HISTORY

Are the child's parents both in good health? If no, please list each health concern and which parent it applies to.	Y	N

Has the child or any family member had any of the following illnesses?	Child		Family		If yes, please indicate who.
Anemia	Y	N	Y	N	
Asthma/Allergies	Y	N	Y	N	
Diabetes	Y	N	Y	N	
Heart Trouble/Murmur	Y	N	Y	N	
Mental Illness	Y	N	Y	N	
Drug Problem	Y	N	Y	N	
Alcohol Problem	Y	N	Y	N	
Inherited Illness	Y	N	Y	N	
Cancer	Y	N	Y	N	
Eye Problems	Y	N	Y	N	
Frequent Ear Infections	Y	N	Y	N	
Problems with Urination	Y	N	Y	N	
Problems with Diarrhea or Constipation or Abdominal Pain	Y	N	Y	N	
Seizures/Headaches	Y	N	Y	N	
AIDS	Y	N	Y	N	
Other	Y	N	Y	N	

Are the child's siblings in good health? If no, please explain.	Y	N
Have any of your children died? If yes, please explain.	Y	N
Please add any additional information you wish to provide about child's family history.		

FEEDING AND NUTRITION

Is your child's appetite usually good?	Y	N

Is it good today? If no, please explain.	Y	N
Was there severe colic or any unusual feeding problem during first 3 months?	Y	N
Do any foods disagree with your child? If yes, please list.	Y	N
For the first 6 months, was your child bottle-fed or breast-fed? If bottle-fed, which formula did you use?	Y	N
Does your child take vitamins? If yes, list the kind of vitamins taken.	Y	N
Please add any additional information you wish to provide about child's feeding or nutrition.		

DEVELOPMENTAL/BEHAVIORAL

Are there any concerns about your child's development?	Y	N
How does your child compare to others of his/her own age?		
Does your child have trouble sleeping?	Y	N
Has your child skipped or repeated any grades?	Y	N
Has your child had any trouble in school? If yes, please explain.	Y	N
Please check any of the following that are applicable to your child: ☐ Nail Biting ☐ Thumb Sucking ☐ Bed Wetting ☐ Bad Temper ☐ Toilet Training Problems ☐ Hyperactivity ☐ Nightmares ☐ Speech Problems		
Has your child had any problems with discipline? If yes, please explain.	Y	N
Please add any additional information you wish to provide about behavior or development.		

SAFETY ENVIRONMENT

Please check your type of residence: ☐ Private home ☐ Apartment ☐ Mobile home ☐ Other		
Is the hottest temperature of the water in your home less than 120 degrees?	Y	N
Is there a working smoke alarm on each floor in the house?	Y	N
Does your child always use a car seat or seat belt when riding in a car?	Y	N
Are there any smokers in the household?	Y	N
Are there any problems with the condition of your home? (insects, rats, peeling paint, etc.)	Y	N
Do you have a record of your child's immunizations?	Y	N
Does your child wear a helmet when riding a bycicle, motor scooter, skateboard, etc.?	Y	N
Please add any additional information you wish to provide about your child's safety environment.	Y	N

THANK YOU.