

ACADEMY PARK PEDIATRICS, P.C.

7373 West Jefferson Ave, Suite 102

Lakewood, CO 80235-2020

4185 East Wildcat Reserve Parkway, Suite 230

Highlands Ranch, CO 80126

NEW PATIENT HISTORY

(Please complete one for each patient)

Date: _____

Patient's Full Name (last, first, middle) _____

Guarantor Name (last, first, middle) _____

Birth Date ___/___/___ 1st visit ___/___/___ Race (optional) _____ Gender _____

BIRTH HISTORY

Birth Weight ___ lbs ___ oz Place of Birth _____ Duration of Pregnancy _____

Delivery: (circle one) C-Section Vaginal Obstetrician _____

Maternal Blood Type: _____ Did your baby receive Hepatitis B vaccine in the hospital? Yes No

Table with 5 columns: Complications (please check each), YES, NO, YES, NO. Rows include Pre-term Labor, Pre-eclampsia/eclampsia, Abnormal Prenatal Ultrasound, Maternal HIV infection, Other Maternal STD, High Blood Pressure, Group B Strep Positive treated during labor, Maternal Hepatitis B, Maternal Herpes Simplex.

Newborn Nursery Complications: _____

Other Maternal Complications: _____

Details if answered "Yes" to any of the above: _____

MEDICAL HISTORY

Hospitalizations (diagnosis, place, dates) _____

Table with 5 columns: Surgery, YES, NO, YES, NO. Rows include Ear Tubes, Hernia Repair, Sinus Surgery, Tonsillectomy/Adenoidectomy, Appendectomy, Surgical Fracture Repair.

Other: _____

Please provide details for any above checked "Yes" (place, date, complication): _____

Medication Allergies: _____

Current Medications: _____

Significant Accidents/Injuries: _____

Table with 5 columns: Significant Medical Problems, YES, NO, YES, NO. Rows include Asthma, Eczema, ADHD, Seasonal Allergies, Migraine Headache, Febrile Seizures.

Medical Problems continued:	YES	NO		YES	NO
Other Seizure Disorder	_____	_____		_____	_____
Diabetes	_____	_____	Heart Condition	_____	_____
Gastric Reflux	_____	_____	Kidney Reflux	_____	_____
Rheumatic Fever	_____	_____	Urinary Tract Infections	_____	_____
Scoliosis	_____	_____	Crohns/Ulcerative Colitis	_____	_____
Irritable Bowel Syndrome	_____	_____	Depression	_____	_____
Hip Dysplasia	_____	_____	Developmental Delays	_____	_____
Hx of Chicken Pox	_____	_____			
Other Medical Problems:	_____				

Date: _____

Please provide details for any above problems checked "Yes": _____

IMMUNIZATIONS: Please attach copy of complete childhood immunization record. If you do not have a copy today it is very important we receive this information as soon as possible.

FAMILY HISTORY

Significant medical problems immediate family of the patient (Parents, siblings, and grandparents only)

	YES	NO		YES	NO
Asthma	_____	_____	Coronary Artery Disease	_____	_____
Seasonal Allergies	_____	_____	High Cholesterol	_____	_____
Eczema	_____	_____	High Blood Pressure	_____	_____
Kidney Reflux	_____	_____	Diabetes	_____	_____
Seizure Disorder	_____	_____	Migraine Headaches	_____	_____
ADHD	_____	_____	Birth Defects	_____	_____
Gastric Reflux/Ulcers	_____	_____	Irritable Bowel Syndrome	_____	_____
Depression	_____	_____	Crohns/Ulcerative Colitis	_____	_____
Growth Disorders	_____	_____	Thyroid Disorder	_____	_____

Other Family History: _____

Please provide details for any above history checked "Yes": _____

SOCIAL HISTORY

Marital Status of Parents: Single: _____ Married: _____ Divorced: _____

If your child is less than 5 years old are they in daycare? **Yes** **No**

If "Yes" how many days per week? _____

Any Pets? **Yes** **No**

If "Yes" what kind? _____

Do any smokers live with or care for this child? **Yes** **No**

If you have any specific problems or concerns about your child, please indicate them below: _____