New Patient Information

David J. Siegler, M.D.

Today's Date: ___________________________

Date of Visit: __________________________ ______________________________________

Pediatrician or Family Physician

Patient's name: __________________________ **Person filling out form:**

Date of Birth: ___________**Age**_____ **Male Female** **Name:** ____________________**relation:** ___________

Reason for Visit ____

Patient's Medical History:

Pregnancy:

At birth, mom's age was: ______ years old

This pregnancy was number ____; was how long? ____weeks

Pregnancy was ☐ normal ☐ not normal: write in space below

Detailed problems with pregnancy?

Birth: Birth weight __________

☐Vaginal delivery ☐ Induced ☐ forceps ☐ Vacuum

☐C-section: Why? ____________________________

☐ was born healthy ☐ not healthy

Detailed problems with birth?

Did mom have premature babies? No☐ Yes☐ How many? ____

Did mom have any miscarriages? No☐ Yes☐ How many? ____

Did mom have any still births? No☐ Yes☐ How many? ____

Has child had any:	**No**	**Yes**	**Details**
Hospitalizations:	☐	☐	____
Surgeries:	☐	☐	____
Serious Illnesses:	☐	☐	____
Head Injuries:	☐	☐	mo/yr _______ Passed out? ______ Vomited? _______Seen by physician?___
Medication Allergies:	☐	☐	Med: __________________Reaction: ________________________
Food/other allergies:	☐	☐	Item: __________________Reaction: ______________________

Present Medications ☐None

_________________Why? __________________

_________________Why? __________________

_________________Why? __________________

_________________Why? __________________

Past Medications	**Why Stopped?**
_________________	______________________
_________________	______________________
_________________	______________________
_________________	______________________

Family History:(circle only the disorders in the family & write person's relation to patient; ie. Mom, maternal uncle)

Migraines	________________	Seizures	________________	Clotting	________________
Headaches	________________	Epilepsy	________________	Aneurysms	________________
Tics	________________	Passing out	________________	Heart Disease	________________
Cerebral Palsy	________________	Muscles	________________	Strokes	________________

School: (circle): too young pre-school grade ______ home-schooled home-bound other: _____

School Performance: A B C D F **Interests?** ____

Lives with? ________________________________**What is home life like?** ________________

What do parents/guardians do? ____

Developmental History: ☐ Normal ☐ Delays

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Patient Name: ____________________ Today's Date: ____________________

Circle any of the following the patient is presently experiencing:

General:

Fatigue   Sleeps a lot   Sleeps poorly

Recent Fevers   Weight Loss   Weight Gain

Ears-Nose-Mouth-Throat

Hearing problems: loss ringing

Hoarse Voice   Onset? ____________

Chokes on food/drink Onset? ____________

Respiratory

Shortness of breath   Onset? ____________

Wheezing   Onset? ____________

Chronic Cough   Onset? ____________

Genito-Urinary

Dark colored urine (like cola)

Wets self (toilet trained) at night during day

Soils self (toilet trained) at night during day

Menstrual periods   Onset? ____________

Skin

Recurrent Rash of face / joints

Coffee spots   How many? _______

White spots   How many? _______

Hematologic

Bruises easily

Bleeding takes long to stop

Psych-Behav

Homocidal or Suicidal thoughts or attempts

Hallucinations   Depressed

Perfectionistic   Overly clean

Obsessive-Compulsive   Lots of fears

Has many rituals

Anger problems   Hurts others

Poor attention   Is easily distracted

Hyperactive   Acts without thinking

Is not very social   Has no friends

Has poor eye contact   Has been arrested

Dislikes seams / tags / tight clothes

Eyes

Vision: poor blind wears contacts / glasses

Eye pain   Onset? ____________

Visual blackouts   Onset? ____________

Double vision   Onset? ____________

Cardiovascular

Chest pains   Onset? ____________

Palpitations   Onset? ____________

Irregular heart beat   Onset? ____________

Gastrointestinal

gags often   Onset? ____________

often nauseated   Onset? ____________

spits-up/vomits often   Onset? ____________

frequent diarrhea   Onset? ____________

chronic Constipation   Onset? ____________

Musculo-Skeletal

muscle pains   muscle cramps

joint pain / swelling   Onset? ____________

reported curved spine

Endocrine

Excessive thirst   Frequent urination

Heat intolerance   Cold intolerance

Neuro (other than for reason for being here)

Headaches

Seizures

Staring spells

Tics

Involuntary movements

Learning Disability

Mental Retardation