New Patient Information (page 1/4)

David J. Siegler, M.D.

Date of Visit: ____________________________ ________________________________

Pediatrician or Family Physician

Patient's name: ___________________________ **Mom:** __________________________________

Date of Birth: ___________**Age**_____ **Male Female** **home:** ______________**other:** ______________

Reason for Visit ___________________________ **Dad:** __________________________________

Patient's Medical History: **home:** ______________**other:** ______________

Pregnancy:

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

Pregnancy was how long?______ weeks

Did mom have any?

	No	Yes	Number
premature babies	No☐	Yes☐	Number: _____
miscarriages	No☐	Yes☐	Number: _____
still births	No☐	Yes☐	Number: _____

During pregnancy did mom have (check boxes)?

No	Yes		No	Yes	
☐	☐	Bleeding	☐	☐	Low blood pressure
☐	☐	Preterm labor	☐	☐	High blood pressure
☐	☐	Seizures or Syncope	☐	☐	Protein or sugar in urine
☐	☐	Major injury	☐	☐	Took meds, drugs, alcohol, smoked

Birth: ☐Normal vaginal delivery

☐ Induced vaginal delivery

☐ Vaginal with forceps

☐ Vaginal with vacuum

☐C-section: Why? ____

Birth weight ______________

Birth activity:

☐Healthy

☐Problems: ________________________________

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? __________________

__________________Why? __________________

Past Medications **Why Stopped?**

__________________ ______________________

__________________ ______________________

__________________ ______________________

__________________ ______________________

__________________ ______________________

Family History: (please mark no/yes and relative's relation to patient; ie. maternal uncle, paternal grandfather, etc.)

ADHD	No☐	Yes☐	__________________	Migraines/Headaches	No☐	Yes☐	___________
OCD	No☐	Yes☐	__________________	Seizures/Epilepsy	No☐	Yes☐	___________
Tics	No☐	Yes☐	__________________	Passing out/Syncope	No☐	Yes☐	___________
Tremors	No☐	Yes☐	__________________	Muscular Dystrophy	No☐	Yes☐	___________
Brain Aneurysms	No☐	Yes☐	__________________	Heart Attacks	No☐	Yes☐	___________
Strokes	No☐	Yes☐	__________________	Heart Rhythm Problems	No☐	Yes☐	___________
Cerebral Palsy	No☐	Yes☐	__________________	High Blood Pressure	No☐	Yes☐	___________

New Patient Information **(page 2/4)**

David J. Siegler, M.D.

What school and grade is (s)he in? ______________________________

How does (s)he do in school? ______________________________

What are his/her interests? ______________________________

Who lives at home? ______________________________

What is home life like? ______________________________

What does mom and dad do? ______________________________

Developmental History

Parental Developmental Concerns:

Milestone	Acquired No Yes	Age when acquired
Rolls over	☐ ☐	________
Sits alone	☐ ☐	________
Uses thumb-finger grasp	☐ ☐	________
Uses "dada" "mama" correctly	☐ ☐	________
Waves Bye-Bye	☐ ☐	________
Walks well	☐ ☐	________
Knows 3 – 5 words	☐ ☐	________
Runs	☐ ☐	________
Uses utensils	☐ ☐	________
Combines words	☐ ☐	________
Knows 5 – 6 body parts	☐ ☐	________
Speech all understandable	☐ ☐	________

Review of Systems (page 3/4)

David J. Siegler, M.D.

Patient Name: ____________________

Today's Date: ____________________

Has the patient ever experienced problems with the following? Check Yes or No
Please provide details where appropriate:

	No	Yes			
General	☐	☐	Fatigue		Onset? ____________________
	☐	☐	Recurrent Fevers		Details: ____________________
	☐	☐	Weight Loss		Details: ____________________
	☐	☐	Weight Gain		Details: ____________________
Eyes	☐	☐	Poor Vision		Details: ____________________
	☐	☐	Eye Pain		Details: ____________________
	☐	☐	Visual Blackouts		Details: ____________________
	☐	☐	Double Vision		Details: ____________________
Ears-	☐	☐	Hoarse Voice		Details?____________________
Nose	☐	☐	Trouble Swallowing		Onset? ____________________
Mouth	☐	☐	Chokes on food/liquid often		Onset? ____________________
& Throat	☐	☐	Bloody nose difficult to stop		Onset? ____________________
CV	☐	☐	Episodes of pounding chest		Details: ____________________
	☐	☐	Episodic Chest Pain		Details: ____________________
	☐	☐	Skipped Heart Beats		Details: ____________________
Respiratory	☐	☐	Episodes of Shortness of breath		Details: ____________________
	☐	☐	Wheezing		Details: ____________________
	☐	☐	Chronic Cough		Details: ____________________
GI	☐	☐	Frequent Gagging		Details: ____________________
	☐	☐	Frequent Nausea		Details: ____________________
	☐	☐	Frequent Vomiting		Details: ____________________
	☐	☐	Gastro-esophogeal reflux		Details: ____________________
	☐	☐	Recurrent Diarrhea		Details: ____________________
	☐	☐	Chronic Constipation		Details: ____________________
Joint-Bones	☐	☐	Recurrent Joint Pain		Details: ____________________
	☐	☐	Recurrent joint Swelling		Details: ____________________
	☐	☐	Curved spine	Severity?	Onset? ____________________
Skin-Hair	☐	☐	Recurrent Facial Rash		Details: ____________________
	☐	☐	Recurrent Rash over Joints		Details: ____________________
	☐	☐	Coffee spots	How many? ________	Where? ____________________
	☐	☐	White spots	How many? ________	Where? ____________________
	☐	☐	Squishy bumps	How many? ________	Where? ____________________
	☐	☐	Hair thinning	(mild / severe)	Onset? ____________________

Review of Systems (page 4/4)

	No	Yes		
Muscles	☐	☐	Long standing Muscle Pain	Details: ____________________
	☐	☐	Frequent Muscle Cramps	Details: ____________________
Endocrine	☐	☐	Excessively thirsty	Onset? ____________________
	☐	☐	Urinates very frequently	Onset? ____________________
Hematologic	☐	☐	Bruises easily	Details: ____________________
	☐	☐	Bleeding takes long to stop	Onset? ____________________

Has the patient ever experienced problems with the following? Check Yes or No
Please provide details where appropriate:

	No	Yes		No	Yes	
Psych-Behav	☐	☐	Suicidal thoughts / attempts	☐	☐	Takes forever to do homework
	☐	☐	Homocidal thoughts	☐	☐	Trouble following directions
	☐	☐	Hears voices that aren't real	☐	☐	Perfectionistic
	☐	☐	Sees things that aren't real	☐	☐	Writes-erases-rewrites often
	☐	☐	Recent loss of someone close	☐	☐	Is very orderly/rigid to a fault
	☐	☐	Change in friends for the worse	☐	☐	Touches stuff all the time
	☐	☐	Reports being "depressed"	☐	☐	Makes noise constantly
	☐	☐	Seems sad a lot	☐	☐	Counts objects often
	☐	☐	Sleeps excessively	☐	☐	Repeats words often
	☐	☐	Gets angry beyond expected s	☐	☐	Has rituals
	☐	☐	Is hyperactive	☐	☐	Obsessed with things
	☐	☐	Acts without thinking	☐	☐	Overly clean
	☐	☐	Is easily distracted	☐	☐	Overly fearful
	☐	☐	Often misplaces schoolwork	☐	☐	Dislikes seams / tags / tight clothes
	☐	☐	Fails to hand in schoolwork	☐	☐	Is not very social
	☐	☐	Disorganized to a fault	☐	☐	Won't make good eye contact

Details:

Mark those neurologic issues below that are **in addition to the reason she/he came today**

	No	Yes		Details:
Neurologic	☐	☐	Headaches	______________________________
	☐	☐	Attention problems	______________________________
	☐	☐	Seizures with fever	______________________________
	☐	☐	Seizures without fever	______________________________
	☐	☐	Sleep problems	______________________________
	☐	☐	Tics	______________________________
	☐	☐	Involuntary movements	______________________________
	☐	☐	Learning Disability	______________________________
	☐	☐	Mental Retardation	______________________________