

NEW PEDIATRIC PATIENT INFORMATION SHEET
(please fill out completely before the appointment)

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____
Patient's Nickname (if any) _____ Pediatrician or Family Doctor _____
Who referred you to our practice (if different) _____

Reason for Today's Visit: _____

Who noticed the problem? _____ When was the problem first noticed? _____
Has the patient seen another doctor for this problem? _____

Review of Systems: Does the patient have problems in these areas and if so, explain, including surgery.

| | <u>Circle:</u> | <u>Explain details:</u> |
|---|----------------|-------------------------|
| <u>Eyes</u> (other than above) | No Yes | _____ |
| <u>Eyes:</u> history of <u>eye surgery</u> | No Yes | _____ |
| <u>General</u> (fever, weight change, tiredness, etc.) | No Yes | _____ |
| <u>Ear/Nose/Throat</u> (reduced hearing, ear tubes, frequent sore throats, etc.) | No Yes | _____ |
| <u>Heart</u> (irregular heart beat, heart abnormality since birth, requirement for antibiotics with dental work or surgery) | No Yes | _____ |
| <u>Lungs</u> (asthma, wheezing, use of inhalers, sleep apnea) | No Yes | _____ |
| <u>Gastrointestinal</u> (reflux, ulcers, diarrhea, constipation) | No Yes | _____ |
| <u>Urologic</u> (kidney or bladder problems) | No Yes | _____ |
| <u>Bones/Joints/Muscles</u> (arthritis, joint swelling or pain) | No Yes | _____ |
| <u>Neurologic</u> (seizures, frequent headaches, prior stroke) | No Yes | _____ |
| <u>Blood</u> (anemia, easy bruising, previous transfusion) | No Yes | _____ |
| <u>Cancer</u> (diagnosis or treatment) | No Yes | _____ |
| <u>Endocrine</u> (diabetes, thyroid disorders) | No Yes | _____ |
| <u>Psychiatric</u> (anxiety, depression) | No Yes | _____ |
| <u>Genetic Syndromes</u> (Down's or others) | No Yes | _____ |
| <u>Other</u> (i.e. developmental delay, autism, ADHD, PDD) | No Yes | _____ |

Prematurity: No Yes If yes, length of pregnancy in weeks: _____ weight at birth _____
Siblings living at home: _____

Current Medications (list): _____

Allergies to Medications (list): _____

Family History of Eye Conditions (list condition and affected relative) for example, lazy eye, wearing eyeglasses before 6 years of age, wearing an eye patch as a child, having eye surgery, childhood cataracts, childhood blindness, childhood eye tumor: _____

Family History of Medical Conditions (list condition and affected relative) for example, parents or siblings with cancer, diabetes, stroke, thyroid disease, high blood pressure _____

