TRINITY PEDIATRICS, P.C.
NEW PATIENT INFORMATION FORM

Patient's name ___________________________________ boy /girl Date of Birth__________
Name of person filling out form?____________________ Relationship to patient________ Date________

FAMILY HISTORY

Patient's mother and father: ___married ___separated/divorced ___dead (mother / father / both)

- If separated/divorced, who has custody of patient? ______________________________
- Does the patient have a sibling outside of the home? Yes / No--- how many?______ Ages?_________

Patient's siblings Date of Birth Live together? Location/Address?

__________________________________ ________________ yes / no
____
__________________________________ ________________ yes / no
____
__________________________________ ________________ yes / no
____

- How many adults live in the home? __________ How many children live in the home? __________
- Is there a family history of illness? __None __Asthma __Diabetes __Seizures __Cancer __Migraines ___Depression ___High Blood Pressure ___Blood problems ___Other____________________

BIRTH HISTORY

- Type of delivery? ___Vaginal ___Cesarean --Why?______________________________
- Where was the patient born?__________________________ Hospital________________________________
- Weight at birth? ____pounds ____ounces Length at birth? ________ inches
- The patient was born _____full term (8-9months) _____premature--how many weeks? _______
- Were there any complications in the pregnancy? No / Yes---what kind? __________________________________
- Were there any complications during the delivery? No / Yes---What kind? _____________________________

ALLERGIES AND VACCINATIONS

- Does the patient have a drug allergy? No / Yes---which medicines?___________________________________
- Does the patient have any food allergies? No / Yes---what foods? ___________________________________
- Does the patient have any material allergies (latex, nickel, etc.)? ______ ________________________________
- Is the patient up to date on vaccines? No / Yes (Please have shot record with you)

PAST MEDICAL HISTORY

- Has the patient been hospitalized? No / Yes--- When? __________ Reason? ___________________________
- Has the patient had any surgery/operations? No / Yes---Reason? ______________________________________
- Does the patient have or has had any of the following? (check all that apply)

___Chickenpox (what age?____) ___Blood in the stool ___Thyroid disease
___Asthma/Bronchitis/RSV
___Eczema or other skin conditions ___Abdomen pain ___Anemia
___Diabetes
___Ear infections (multiple) ___Constipation ___Seizures
___Kidney disease/infection
___Problems with hearing/ vision ___Frequent diarrhea ___Headaches/Migraines ___Blood problems
___Heart problems
___Other---____

- Has the patient begun her period/menstruation? No / Yes---age started? ___ having problems?_____________