Collins Pediatrics

New Patient Medical History

Please complete one new patient medical history form for each patient.

Patient Information

First Name_____
Last Name_____
Address_____
City_____State_____Zip_____
Primary Phone_____
Date of Birth_____
Gender □ Male □ Female

Birth History

Obstetrician_____
Hospital_____
Delivery Method □ Vaginal □ C-Section
Complications_____
_____
Weight_____
Length_____
Blood Type_____

Developmental History

Rolled_____
Sat Up_____
Stood_____
Walked_____
Words_____
First Tooth_____
Bladder Control_____
Bowel Control_____

Other Physicians Seen:

ENT_____
Cardiologist_____
Psychologist_____
Other_____
_____
_____

Diet/ Feeding History (Fill in ages when started/ completed)

Breast Milk_____
Formula_____
Cereals_____
Fruits/ Veggies_____
Tables Foods _____
Present Diet_____
_____

Allergies

Drug Allergies_____
Food Allergies_____
Seasonal Allergies_____
Other_____

Past Medical History

Previous MD_____
List any medical problems your child has had
_____
_____
_____
_____
_____

Past Surgical History

List any surgeries or procedures your child has had

Surgery	Doctor	Date

A photocopy or scan of this authorization shall be considered as effective and valid as the original.

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Current Medications

List all current medications your child is taking

Medication Dosage

_____

_____

_____

_____

Immunizations

Are immunizations up to date □ Yes □ No

If they are not up to date, why?

_____

_____

_____

Concerns/ Goals

_____

_____

_____

_____

_____

_____

Signature of parent/ guardian_____

Date_____

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