Helping Hands Pediatrics

New Patient Medical Information

Date: _____

Child's Name: _____ Date of Birth: _____

1. Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

2. Allergies: _____
3. List all medications taken on a regular basis with dosage amounts: _____
   _____
4. Pregnancy and birth history:

   Hospital: _____

   Was baby premature? Yes No

   Was baby born by C-Section? Yes No

   Did baby have to stay in the nursery longer than expected after delivery? Yes No

   Please list any health problems during pregnancy, labor and delivery that effected baby:
   _____
5. Please circle if your child has been diagnosed with the following:

   Asthma ADHD Diabetes Digestive Problem Heart Condition

   Kidney Disease Seizures Other: _____
6. List any specialists that your child sees regularly_____
   _____
7. List all of your child's surgeries/dates:_____

   _____
8. Date of last physical exam: _____