Helping Hands Pediatrics

New Patient Medical Information

				Date:	
nild's Name:			Date of Birth:		
Pharmacy: _		Pharr	macy Phone Number:		
cy Address: _					
Allergies:					
List all medi	cations taken or	ı a regular basis w	vith dosage amounts:		
Pregnancy a	nd birth history				
Hospital:					
Was baby pr	emature? Yes	No			
Was baby bo	orn by C-Section	? Yes No			
Did baby hav	ve to stay in the	nursery longer th	nan expected after delive	ery? Yes No	
Please list ar	ny health proble	ms during pregna	ancy, labor and delivery	that effected baby:	
Please circle	if your child has	s been diagnosed	with the following:		
Asthma	ADHD	Diabetes	Digestive Problem	Heart Condition	
Kidn	ey Disease	Seizures	Other:		
List any spec	cialists that your	child sees regula	rly		
	Pharmacy: _ cy Address: _ Allergies: List all media Pregnancy a Hospital: Was baby pr Was baby pr Was baby pr Did baby hav Please list ar Please circle Asthma Kidn	Pharmacy:	Pharmacy: Pharmacy: cy Address:	Pharmacy: Pharmacy Phone Number: cy Address: Allergies: List all medications taken on a regular basis with dosage amounts: 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 deliver Please list any health problems during pregnancy, labor and delivery Please circle if your child has been diagnosed with the following: Asthma ADHD Diabetes Digestive Problem	