New Patient Registration Form

NAME: _____ BIRTHDATE: _____ DATE: _____

How much did your child weigh at birth? _____

How many weeks before birth? (If not known, write full term, early, or late) _____

Born naturally or C-section? _____ Hepatitis B given in hospital? (Y / N)

How long was your child in the hospital after birth? _____

List all CURRENT PRESCRIPTION MEDICINES (Include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

_____

ALLERGIES: _____ SENSITIVITIES: _____

_____ _____

List SURGERIES you have had (Include reason and year): _____

_____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (Include reason and year): _____

_____

_____

_____

Who in your *FAMILY* has/had (circle if cause of death and write age of death)

Heart disease _____ Genetic disorder _____

Diabetes _____ Cancer _____

seizure_____ _____ High cholesterol_____

Mental illness _____ Sudden death_____

Bleeding disorders_____ Asthma _____

Allergies _____ Stomach problems _____

Tuberculosis _____ High blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed.

_____

Who lives in your household? _____

_____

Do you have any pets? _____

Does anyone smoke? If so, please list what type, how much, and how often. _____

Do your children go to daycare? _____

Signature:_____ Date:_____