NEW PATIENT / WELL CHILD FORM

(Returning / Established patients may skip Birth History)*

Name: ____ Date or Birth: ___________________ Today's Date:________________

□Male □Female | Person completing form / relationship: ____

Birth History: Mother's age at birth _______

Indicate any medical problems or other relevant issues during pregnancy: ____

List any medications taken by mother during pregnancy: ____

Delivered by: □Vaginal □C-Section | If C-Section list reason: ____

Number of weeks gestation or indicate full term _____________ Birth weight ___________ | Birth Length __________

Hepatitis B vaccine given: □No □Yes | If yes, date given: ____________

Please list any serious medical problems during the newborn period: □ None _______________________________

____

Medications: □None

Name ______________________ Dose _________ Frequency _________

Name ______________________ Dose _________ Frequency _________

Medication Allergies: □NKDA

Medication _______________ Reaction__________

Medication _______________ Reaction__________

Social History:

Parent's Marital Status: □Married □Divorced □Single

Who else besides parents cares for the child regularly?

□Daycare □Babysitter/Nanny □ Grandparents □ Other Family

Name / DOB of any siblings: #1 ________________________

#2 ____________________ #3 ________________________

#4 ____________________ #5 ________________________

Safety / Environment:

Are there any smokers in the home?

□No □Yes

Are there and concerns about lead exposure?

□No □Yes

Are there any problems with the condition of your home? □No □Yes

Family History: Indicate if present in any of your child's parents, siblings, grandparents, aunts/uncles, or first cousins

✓	Diagnosis	Family Member	✓	Diagnosis	Family Member
	ADD/ADHD			High cholesterol	
	Anemia/Bleeding disorder			Immune disorder	
	Asthma/Lung disorder			Intestinal/Liver disease	
	Birth defect			Mental retardation	
	Cancer			Metabolic/Muscle disorder	
	Deafness/Hearing loss			Neurologic disorder	
	Diabetes			Psychiatric disorder	
	Genetic disease/Syndrome			Urinary tract/Kidney disease	
	Eczema/Skin disease			Seizures	
	Heart disease/Stroke			Thyroid disease	
	High Blood Pressure			Tuberculosis	

Past Medical History: List any major medical problems: □None ____

List any hospitalizations other than birth (include reason and date(s)): □None ____

To the best of my knowledge, my child is up to date on his/her immunizations: □No □Yes | If No, why? ________________________

Feeding & Nutrition:

History of colic/reflux? □Yes □No

Any unusual feeding/diet? □Yes □No

Development:

At what age did your child?

Sit _______ Walk _______ Say words _______

Dental History:

Has child been seen by dentist?

□Yes □No | Last Visit ________

Blood / Lymph:	□Unexplained Lumps | □Easy Bruising / Bleeding
Cardiovascular:	□Tires Easily w/Exertion | □Chest Pain | □Fainting | □Palpitations
Ears / Nose / Throat:	□Hard of hearing | □Mouth Breathing | □Snoring | □Chronic Runny Nose / Congestion / Sore Throat
Eyes:	□Squinting | □Crossed Eyes | □Asymmetric Gaze
Gastrointestinal:	□Adominal Pain | □Nausea/Vomiting | □Diarrhea | □Constipation | □Blood in Feces | □ Feeding issues
General:	□Fever | □Chills | □Excessive Sweating | □Unexpected Weight Gain / Loss, How much Gain / Loss _______lbs
Genitourinary:	□Bedwetting | □Pain w/Urination | □Frequent Urination | □Discharge: penile or vaginal
Musculoskeletal:	□Muscle Aches or Pain | □Joint Aches or Pain
Neurological:	□Headaches | □Weakness | □Clumsiness
Psychiatric / Emotional / Behavioral:	□Speech Problems | □Anxiety/Stress | □Depression | □Suicidal Thoughts | □Aggressive/Concerning Behavior
Respiratory:	□Cough | □Wheeze | □Shortness of Breath
Skin:	□Rashes | □Unusual Moles

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Form must be completed for all persons under the age of 18 years

The Texas Family Code allows only certain people to consent to medical treatment for minors if parental consent cannot be obtained. These are:

1. A grandparent
2. An adult sister or brother (over the age of 18 years)
3. An adult aunt or uncle
4. An educational institution in which your child is enrolled, which has written authorization to consent to treatment
5. Any adult who has care and control of the child and who has written authorization from the parent to consent to treatment.

I, ______________________________, am

☐ the parent

☐ the guardian (specify relationship)________________________________

of the minor child, _________________________________, and hereby authorize Dallas Family Medical & Aesthetics and/or its authorized agents, to consent to what ever medical treatment they may deem necessary while said minor is under their care in accordance with Texas Family Code Section 32.001.

Nature of expected medical treatment: Well Child Physical Exam and/or Follow up visit

Date treatment is expected to begin: ___________

______________________	______________________	___________
Parent/Guardian Name	Parent/Guardian Signature	Date