molly rad M.D. PEDIATRICS

NEW PATIENT SCREENING

Today's Date: _____

Patient Name: _____ Nickname: _____
Date of Birth: _____
Mother's Name: _____ Father's Name: _____

If adults in the household work outside the home, what childcare arrangements are made for this child?
_____

PAST MEDICAL HISTORY

	YES	NO
1. Has your child had any allergic reactions to any medication and/or insect bite?	☐	☐
If yes, which ones? _____		
2. Has your child had any reactions to any immunizations?	☐	☐
If yes, which ones? _____		
3. Any hospitalizations other than birth?	☐	☐
If yes, what for? _____		
4. Any serious injuries?	☐	☐
What kind'? _____		
5. Are any medications taken regularly?	☐	☐
For what and which ones?_____		

FAMILY HISTORY:

1. Are the child's parents both in good health?
2. Check any diseases that this child's parents, brother, sisters *or* aunts uncles have had:

☐ Anemia	☐ Asthma	☐ Allergies	☐ Diabetes
☐ High Blood Pressure	☐ Heart problem	☐ Tuberculosis	☐ Mental illness
☐ Drug Problems	☐ Alcohol Problems	☐ Inherited Illness	☐ Venereal Disease
☐ Cancer	☐ AIDS	other: _____	

FEEDING AND NUTRITION:

1. Is your child's appetite usually good?	☐	☐
2. Do any foods disagree with him or her?	☐	☐
3. Does he or she take vitamins?	☐	☐

REVIEW OF SYSTEMS:

1.	Any eye problems?	☐	☐
2.	Does he or she have frequent colds or sore throat?	☐	☐
3.	Is there Asthma or Pneumonia or recurrent coughs?	☐	☐
4.	Does he or she have a heart murmur?	☐	☐
5.	Any problems with diarrhea or constipation?	☐	☐
6.	Have there been any convulsions or other problems with the nervous system?	☐	☐
7.	Any eczema, hives or other skin problems?	☐	☐
8.	Has your child ever been anemic?	☐	☐
9.	Please list any other medical problems:	☐	☐

_____

_____

DEVELOPMENT BEHAVIOR:

1. At what age did he or she walk? _____
2. Did he or she say any words by the time he or she was 1 ½ years old?
3. Has he or she had any trouble sleeping?

   If yes, please specify _____
4. What grade is he or she in? _____
5. he or she have any trouble in school?

   If yes, &ease specify: _____
6. Does he or she get along with other children?
7. Check if your child has had or have any of the following:

☐ Nail biting	☐ Thumb sucking	☐ bed wetting	☐ bad temper
☐ speech problems	☐ hyperactivity	☐ nightmares	☐ discipline problems
☐ toilet training problems		☐ other: _____	

SAFETY AND ENVIRONMENT:

1. is there a working smoke alarm on each floor in the house? ☐ ☐
2. Does your child always use a car seat/seat belt when riding in the car? ☐ ☐
3. Are there any smokers lit the household? ☐ ☐
4. Does your child always wear a helmet when riding his or her bicycle? ☐ ☐

DO YOU HAVE A RECORD OF IMMUNIZATIONS?

FOR OFFICE USE ONLY:

Date: _____

Notes: _____

Physician: _____