# CATALYST MEDICAL CLINIC — NEW PATIENT RECORD - Pediatrics

PATIENT NAME: _____

DOB: _____ SEX ☐ Male ☐ Female

REFERRED BY: _____

**Chart No.**

DATE _____

MOTHER'S NAME: _____ AGE _____

PH (H) _____ PH (W) _____

ADDRESS _____

MOTHER'S EMPLOYER _____

FATHER'S NAME: _____ AGE _____

PH (H) _____ PH (W) _____

ADDRESS _____

FATHER'S EMPLOYER _____

## CURRENT MEDICAL HISTORY

Is your child having any medical problems? ☐ Yes ☐ No

_____

_____

_____

_____

Is he/she taking any medication? ☐ Yes ☐ No

_____

Are immunizations current? ☐ Yes ☐ No

## MATERNAL and NEWBORN HISTORY

**Pregnancy** *(Check problem areas)*

☐ Excessive wt. gain ☐ Urinary infections ☐ Excessive swelling

☐ Rubella ☐ Toxemia ☐ Venereal disease

Alcohol/recreational drugs used during pregnancy? ☐ Yes ☐ No

_____

**Birth** Delivery: ☐ Vaginal ☐ Caesarean Section _____

Baby was ☐ Full term ☐ Premature Birth wt _____

Was labor difficult or prolonged? ☐ Yes ☐ No _____

Was delivery difficult or complicated? ☐ Yes ☐ No _____

_____

**Newborn** ☐ Breast ☐ Formula _____

☐ Feeding problems ☐ Colic ☐ Multiple formula changes

☐ Blood in stools ☐ Slow wt. gain ☐ Recurring vomiting

☐ Recurring diarrhea ☐ Jaundice ☐ Other _____

_____

## IMPORTANT MEDICAL PROBLEMS or DIAGNOSES

_____

_____

_____

## DRUG ALLERGIES

_____

_____

_____

## PAST MEDICAL and FAMILY HISTORY

Has the patient or any family member been hospitalized for a medical or surgical problem ☐ Yes ☐ No _____

_____

_____

*If the patient or any family member has or has had any of the following problems, check the appropriate box and list the family members initial:*

P - Patient M - Mother GM - Grandmother

S - Sibling F - Father GF - Grandfather

1. ☐ Trauma: Broken bones, loss of consciousness _____
2. ☐ Allergies _____
3. ☐ Drug allergies _____
4. ☐ Asthma _____
5. ☐ Eczema _____
6. ☐ Resp. infection _____
7. ☐ Ear infections _____
8. ☐ Tuberculosis _____
9. ☐ Immunity prob. / HIV ____
10. ☐ High cholesterol _____
11. ☐ High blood pressure _____
12. ☐ Heart attack / stroke before age 55 ____
13. ☐ Other heart problems ____
14. ☐ Anemia / Blood disorders _____
15. ☐ Diabetes _____
16. ☐ Obesity _____
17. ☐ Bladder / Kidney _____
18. ☐ Stomach / GI _____
19. ☐ Cancer _____
20. ☐ Seizures _____
21. ☐ Growth _____
22. ☐ Hereditary _____
23. ☐ Learning problems _____
24. ☐ Attention Deficit / Hyperactivity
25. ☐ Emotional / Behavioral ___
26. ☐ Psychiatric _____
27. ☐ Alcohol or Drugs _____

Do you have any other concerns you wish to discuss?

☐ Yes ☐ No _____

Parent's Signature: _____ DATE _____

**Provider Comments:**

Provider's Signature: _____ DATE _____

| | | | | |
|---|---|---|---|---|
| History Updated (date) | | | | |
| | | | | |