Lilia Fernandez Coppa, MD

"Healthy children, happy families ~ Niños sanos, familias felices"

New Patient Medical History

Patient's Name _____ Date _____
Date of Birth _____ Age Today _____
Do you have a record of your child's immunizations with you today? _____

PREGNANCY AND BIRTH

Mother's age at birth _____ Did mother have any illness during pregnancy? _____
Did she take any medications other than vitamins and iron? _____
What hospital/birth center? _____ Was the baby on time? _____
Was the birth by C-section or vaginal? _____ Obstetrician/Midwife name _____
Pediatrician _____ What was the birth weight? _____ Length _____
Did the baby spend time in NICU or have any medical problems? _____
Did the baby receive Hepatitis B vaccine in the nursery? _____
Please note any other important facts _____

FAMILY HISTORY

Are the child's parents both in good health? _____
Check any diseases that the child's siblings, parents grandparents, aunts, uncles, or 1st cousins have: ☐ AIDS, ☐ alcohol problems, ☐ allergies, ☐ asthma, ☐ blood disorders, ☐ cancer, ☐ diabetes, ☐ drug problems, ☐ epilepsy, ☐ heart trouble, ☐ high blood pressure, ☐ high cholesterol, ☐ inherited illness, ☐ kidney disease, ☐ liver disease, ☐ lung disease, ☐ lupus, ☐ mental illness, ☐ multiple sclerosis, ☐ muscular dystrophy, ☐ SIDS, ☐ tuberculosis, ☐ venereal disease, ☐ others.

Siblings Names:	Birth Date:	Sex:	General Health (Problems):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any siblings died? _____ If yes, cause of death: _____

PAST MEDICAL HISTORY

Where has your child gone for check-ups until now? _____
Date of last check-up _____ Date of last dental check-up _____
Any allergic reactions to any medications, foods, or insect bites? ○ **Y** ○ **N** Which? _____
Has your child had a bad reaction to any immunizations? ○ **Y** ○ **N** Which? _____
Any hospitalizations/surgeries other than birth? _____ Reason? _____
Any chronic illnesses? ○ **Y** ○ **N** If so, please list _____
Any serious injuries/broken bones/stitches? ○ **Y** ○ **N** What kind? _____
Are medications taken regularly? ○ **Y** ○ **N** Which? _____

REVIEW OF SYSTEMS

Has your child had frequent ear infections? ○ **Y** ○ **N**
Any hearing problems? ○ **Y** ○ **N**
Any vision problems? ○ **Y** ○ **N**
Frequent colds/sore throats? ○ **Y** ○ **N**
Does s/he have a history of allergies, asthma, pneumonia, bronchitis, or recurrent cough? ○ **Y** ○ **N**

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New Patient Medical History 2

Does s/he have a heart murmur, or any heart problems? ○ **Y** ○ **N** Has your child ever been anemic? ○ **Y** ○ **N**
Any problems with kidneys/bladder/urination? ○ **Y** ○ **N** Has s/he had any problem with teeth? ○ **Y** ○ **N**
Any problems with diarrhea/constipation? ○ **Y** ○ **N** Any eczema, hives, or other skin conditions? ○ **Y** ○ **N**
Have there been any convulsions or other problem with the nervous system? ○ **Y** ○ **N**
Has your child seen a specialist? ○ **Y** ○ **N** If so, for what? _____

SAFETY ENVIRONMENT

Do you know the hottest temperature of the water in your pipes? ○ **Y** ○ **N**
Is there a working fire alarm on each floor in the home? ○ **Y** ○ **N**
Is there a working fire extinguisher in the home? ○ **Y** ○ **N**
Does your child always use a car seat/seat belt when in the car? ○ **Y** ○ **N**
Are there any problems with the condition of your home? (peeling paint, insects, rats or mice) ○ **Y** ○ **N**
Does your child always wear a helmet when riding a bicycle/skateboard or other activities? ○ **Y** ○ **N**
Are there pets in the home? ○ **Y** ○ **N** If yes, how many, and what types? _____
Are there guns in the house? ○ **Y** ○ **N**
Is there a swimming pool located at the home? ○ **Y** ○ **N**

FEEDING AND NUTRITION

Current nutrition: ☐ breast fed ☐ formula fed ☐ table food
For the first 6 months was this child ☐ breast fed or ☐ formula fed?
If formula fed, which one? _____ How many ounces? _____
If on regular milk, which? ☐ Whole ☐ 2% ☐ 1% Amount/day _____
Is your child's appetite usually good? ○ **Y** ○ **N** Is it good now? ○ **Y** ○ **N**
Was there severe colic or any other unusual feeding problems during the first three months? ○ **Y** ○ **N**
Do any foods disagree with him/her? ○ **Y** ○ **N**
Does s/he take vitamins/fluoride? ○ **Y** ○ **N**

DEVELOPMENT/BEHAVIOR

(answer if child is less than 5 years - ONLY)

At what age did this child sit alone? _____ At what age did s/he walk alone?_____
Did s/he say any words by 15 months of age? _____
How does this child's behavior/development compare to others his or her age? ○ same ○ advanced ○ behind
Are there any problems with sleeping? ○ **Y** ○ **N** Is child in day care? ○ **Y** ○ **N**

(answer if child is older than 5 years - ONLY)

What grade is this child in? _____ School's Name_____
Has s/he had any trouble with school? ○ **Y** ○ **N** Does s/he get along well with other children? ○ **Y** ○ **N**
Does your child have any of the following: ☐ nail biting, ☐ thumb sucking, ☐ bed wetting, ☐ bad temper, ☐ problems with toilet training, ☐ hyperactivity, ☐ nightmares, ☐ speech problems, ☐ problems with discipline, ☐ others. _____

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