Metropolitan Pediatrics

NEW PATIENT HEALTH BACKGROUND

Patient Name: ______________________________ **Date of Birth:** ______________________

Does the child have any chronic health problems? If yes, please list.

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Does the child have any allergies such as asthma, hay fever, medication allergies? If yes, please list.

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Has the child ever been hospitalized? If yes, list reason and date hospitalized.

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Yes	No	
		Is the child on medication all the time?
		Is the child on a special diet?
		Has the child had any surgery?
		Does the child have any developmental delays?
		Is there a family history of any diseases or genetic problems or require special education?
		Was your house or apartment built before 1960?
		Are you on a fluoridated city water supply?
		Does the child participate in organized sports?
		Does the child have any serious behavioral problems?
		Do you have any major concerns regarding the child?
		Are the child's immunizations up-to-date?
		Has the child had Chickenpox?