Patients Name _____

Date _____

Santa Clarita Pediatrics

NEW PATIENT INFORMATION

Do you currently have any of the following?

Yes	No	
☐	☐	Fever
☐	☐	Weight loss or gain
☐	☐	Headache
☐	☐	Blurry vision
☐	☐	Itchy/red eyes
☐	☐	Difficulty hearing
☐	☐	Sore throat
☐	☐	Ear Pain
☐	☐	Runny nose
☐	☐	Cough
☐	☐	Wheezing
☐	☐	Heart murmur
☐	☐	Chest pain
☐	☐	Constipation
☐	☐	Feeding issues
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Abdominal pain
☐	☐	Frequent urination
☐	☐	Joint swelling or pain
☐	☐	Muscle weakness or pain
☐	☐	Sleeping problems
☐	☐	Behavioral concerns
☐	☐	Asthma
☐	☐	Nasal congestion
☐	☐	Speech problems
☐	☐	Developmental concerns
☐	☐	Seizures
☐	☐	Other_____

Who lives in the household? _____

_____

_____

Any smokers? _____

Pets _____

Family History

Yes	No	
☐	☐	Obesity
☐	☐	High blood pressure
☐	☐	Asthma
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Allergies
☐	☐	High Cholesterol
☐	☐	Developmental delay

Prior Surgeries / Hospitalizations	Year
_____	_____
_____	_____
_____	_____
_____	_____

Birth ht. _____ Birth wt._____

Any complications? _____

Allergies

List allergies to medications or substances

_____

_____

Medications

_____

_____

_____

Are immunizations up to date? Yes ☐ No ☐