olson PEDIATRICS

New Patient History Form, Ages 0-5 years

Name	Date of birth
Birth weight	Hospital name and location
☐ Vaginal delivery ☐ Cesarean delivery	Any complications, NICU stay?
Was your child breastfed? If so, for how long?	Age sat up? Age walked? Age talked?
Is your child taking any medications or supplements?	
Does your child have any food or drug allergies?	
Are your child's vaccines up to date?	
Does your child have any medical conditions or developmental delays?	
Has your child been hospitalized overnight other than birth or had surgery?	
Does your child have a dental home? When was the last dental visit?	
Who does the child live with? (Please list names, ages and relations)	
Do the parents of the child live separately? If so, is there a visitation schedule?	
Does anyone in the household smoke? Even if outside the home?	
Does the child attend daycare/school? If so, how many hours/days per week?	
Is there anything else you would like the doctor to know about your child or your family?	