



olson PEDIATRICS

New Patient History Form, Ages 6-11 years

Name	Date of birth
Birth weight	Hospital name and location
Does your child have any medical conditions or developmental delays?	
Has your child been hospitalized overnight other than birth or had surgery?	
Are your child's vaccines up to date?	
Does your child have any food or drug allergies?	
Is your child taking any medications or supplements?	
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 outside?	
What school does the child attend? What grade?	
Is there anything else you would like the doctor to know about your child or your family?	