SIERRA VISTA HOSPITAL & CLINICS

800 East 9th Avenue, Truth or Consequences
Hospital: 575.894.2111 Clinics: 575.894.3221

NEW PEDIATRIC PATIENT

Full name: _____ **Date of birth:** _____ / _____ / _____

Form completed by: ☐ Self ☐ Other Name _____ Relationship:_____

Allergies ☐ None

Allergy	Reaction

Medications and Supplements ☐ None

Medication/Supplement	Dose	Times per Day

Surgeries and Hospitalizations ☐ None

Type	Date	Location/Facility

Prenatal/Antenatal history (For infant and young child patients)

Did mother receive prenatal care? ☐ YES ☐ NO If yes, where?	
Any complications during the pregnancy? ☐ YES ☐ NO If yes, what were they?	
Was patient born at term (37 weeks or more)? ☐ YES ☐ NO	Birth weight:
Type of feeding: ☐ Breast ☐ Bottle ☐ Both	

Developmental History

Were you ever concerned about your child's development? ☐ YES ☐ NO If yes, please explain
Does your child currently receive any special therapy such as OT, PT or speech? ☐ YES ☐ NO If yes, please explain
Does your child currently receive any special educational therapy such as Early Intervention or Special Education? ☐ YES ☐ NO If yes, please explain
Any concerns about your child's behavior? ☐ YES ☐ NO If yes, please explain

Personal Medical History ☐ None

✓	Disease/Condition	Date of Diagnosis
	Alcohol use/Tobacco use/Drug use	
	Asthma	
	Birthmarks	
	Cleft lip/cleft palate	
	Depression/Anxiety	
	Suicidal/Bipolar	
	Diabetes	
	Failure to thrive	
	Heart problem (murmur, abnormal rhythm)	
	High blood pressure	
	Large tongue/macroglossia	
	Kidney disease	
	Thyroid disease	
	Migraine/headache	
	Overweight/Obesity	
	Recurrent infections	
	Anemia	
	Stomach issues (pain, heartburn, etc.)	
	Seizures/Epilepsy	
	Crohn's disease/Ulcerative Colitis	
	Bleeding issues	

Infection History Please check all that apply

✓	Infection	✓	Infection
	Chickenpox/Varicella		Frequent colds
	Measles		Pneumonia
	Mumps		Rheumatic Fever
	Rubella		Tonsillitis
	Scarlet fever		Recurrent ear infections

Vaccinations up to date? ☐ YES ☐ NO ☐ UNSURE

Health Maintenance

Test	Date	Facility/Provider	Abnormal Result? Y or N
Hearing test			
Vision Test			
Autism Screen			

Family Medical History: ☐ None ☐ Unknown

Please check all that apply	Alcohol/drug use	Asthma	Cancer: (type___)	COPD	Depression/anxiety	Bipolar/suicidal	Diabetes	Early death	Heart disease	High blood pressure	Kidney disease	Stroke	Thyroid disease	Migraines	Autoimmune disease
Mother															
Father															
Brother															
Sister															
Child															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															

Social History

Does your child currently attend school/daycare? ☐ YES ☐ NO
If yes, what school does your child attend?
What grade is your child in?

Anyone smoke in home?
If yes, inside the home or outside the home?

Tobacco use? ☐ YES ☐ NO **If yes…** ☐ Cigarettes? ☐ Cigars? ☐ Vaping? ☐ Chewing tobacco?

Answer if CURRENT USER	**Answer if FORMER USER**
How many per day? **How many years?** **Are you interested in quitting?**	**Quit date:** **How many per day?** **How many years?**

Does your child drink alcohol? ☐ YES ☐ NO **If yes, how many drinks per day?**

Does your child use recreational substances? ☐ YES ☐ NO
Has your child ever used needles to inject drugs? ☐ YES ☐ NO

Is your child sexually active? ☐ YES ☐ NO
Birth control method: ☐ None ☐ Condom ☐ Pill ☐ Patch ☐ Ring ☐ Nexplanon ☐ IUD ☐ Depo Provera

Does your child exercise regularly? ☐ YES ☐ NO
If yes, how long?
How often?

How many hours of sleep does your child get on average?	**How would you rate your child's diet?** ☐ Good ☐ Fair ☐ Poor

Other Providers/Specialists ☐ None

Providers/Facility	Specialty

Review of Systems: Please Check All That Apply

✓	**CONSTITUTIONAL**	✓	**CARDIOVASCULAR**	✓	**MUSCULOSKELETAL**
	Fever		Chest pain		Joint pain
	Chills		Heart racing/palpitations		Joint swelling
	Sweats		Heart fluttering		Leg pain with walking
	Fatigue		Leg swelling		Muscle aches
	Appetite Changes				Neck pain/neck stiffness
	Weight Changes	✓	**GASTROINTESTINAL**		Increased muscle tone
			Abdominal pain		Muscle weakness
✓	**ENT/Head/Eyes**		Nausea/vomiting		
	Change in vision		Constipation	✓	**NEUROLOGICAL**
	Ear pain		Diarrhea		Dizziness
	Ear discharge		Acid reflux/heartburn		Lightheadedness
	Hearing loss/ringing of ears		Blood in stool		Balance problems
	Nosebleeds		Pain in rectum		Paralysis of any body part
	Sinus pressure				Headaches
	Sneezing	✓	**ENDOCRINE**		Numbness/Tingling
	Facial swelling		Hair changes		Seizures
	Sinus congestion		Skin changes		Tremors
	Mouth sores		Increase thirst		Weakness
	Sore throat		Increased hunger		
	Trouble swallowing			✓	**PSYCHIATRIC**
	Drooling	✓	**GENITOURINARY**		Increase in stressors
			Pain with urination		Behavior issues
✓	**RESPIRATORY**		Urinary frequency		Confusion
	Cough		Increased urinating at night		Depression
	Shortness of breath		Blood in urine		Anxiety/Agitation
	Wheezing		Painful periods		Decreased concentration
	Sputum		Heavy periods		Hallucinations
	Chest tightness		Irregular periods		Sleep disturbances
	Choking		Abnormal genital appearance		Suicidal thoughts
	Loud snoring		Testicular pain		
			Genital sores	✓	**OTHER ISSUES**
✓	**HEMATOLOGICAL**				
	Easy bruising/bleeding	✓	**SKIN**		
	Swollen lymph nodes		Rashes		
			Ulcers/wounds		
			Changing mole		