Carolina Pediatrics of the Triad, PA
New Patient History Form

Patient Name:_____ DOB:_____ Preferred Language: _____

Patient Past Medical History – *Please list any past surgeries, injuries, or prior hospitalizations for patient:*_____

Patient Allergies – *Please list any known allergies to food, medicine, or other known causes:* _____

Medications – *Please list any current medications:* _____

Please list any other doctors the patient has been referred to or has seen in the past: _____

Please place an "X" in the box under the patient or family member with the illness and list type of illness where requested.

Illness	Patient	Mom	Dad	Brother	Sister	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Allergies (medicine, food, seasonal)									
Anemia (iron deficiency, thalassemia)									
Asthma									
ADD/ADHD									
Autistic Spectrum Disorder									
Autoimmune Disorder (Please Specify)									
Bleeding Disorder (Please Specify)									
Cancer (Please Specify)									
Circulation Problem/ Vascular Disorder									
Clotting Disorder									
Cystic Fibrosis									
Deafness (congenital or acquired)									
Developmental Disorder									
Diabetes (Please Specify)									
Down Syndrome									
Eye Disorder (Please Specify)									
Genetic Disorder (Please Specify)									
Headache									
Heart Attack/MI (Specify if younger than 50)									
Heart Defect (Please Specify)									
Heart Rhythm Disorder									
High Blood Pressure									
High Cholesterol									
Immune Deficiency									
Immunocompromised (Reason : ie. Medicine)									

Illness	Patient	Mom	Dad	Brother	Sister	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Kidney Disease									
Learning Disorders									
Liver Disease									
Mood Disorder (Please Specify)									
Psychiatric Disorder (Please Specify)									
Reflux/Ulcers (Please Specify)									
Seizure Disorder (Please Specify)									
Sickle Cell (Trait or Disease)									
SIDS									
Sleep Apnea									
Stroke (Specify if younger than 50)									
Substance Abuse									
Sudden Death (unknown or cause)									
Thyroid Disorder (Please Specify)									
Transplant (Please Specify)									

List any other not mentioned above: _____

Social:

Who lives in the home with the child (Please list ages)? _____

_____

Smokers who live in the home? ☐ Yes or ☐ No If yes, do they smoke: ☐ Outside or ☐ Inside/Outside

Water Source:

- ☐ Well Water
- ☐ Public Water

Does the Child Attend:

- ☐ Daycare
- ☐ Preschool
- ☐ School