New Patient Form for Children 5 and under

Today's Date: _____

Age of the child: ____ Date of Birth: _____ Sex: _____

Name of Child: _____

Name of Parent: _____

Address: _____

Phone #: _____

Referred by: _____

Any significant event happened before birth? _____

Anything unusual about Prenatal history? _____

Was he/she born healthy? _____

Height at birth: _____ Weight at birth: _____

Apgar score if available: _____

Was it a normal delivery? _____

If not what kind? _____ C Section? _____ Forceps? _____

Any birth traumas? _____

Any trauma during infancy? _____ What age? _____

Any other trauma during infancy? _____

Did the child receive Vitamin K injection on the first day of birth? _____ Hepatitis B? _____

Silver Nitrate (Neomycin or Neosporin) in the eyes on the day of delivery? _____

What other symptoms parent noticed soon after birth? _____

A couple days after? _____

Did he/she have any discomfort? _____

Spitting up? _____ Vomiting? _____

Was he/she breast fed? _____ for How long? _____

When was the solid food introduced? _____

Cried a lot? _____

Breathing difficulties? _____ Asthma? _____ Eczema? _____

Bronchitis? _____ Hives? _____

Any medication given for any of these symptoms? _____

Does he/she have siblings? _____ Is he/she the first born? _____

If not what is the position of the child? _____

Did he/she have all childhood vaccinations? _____

List the vaccinations:

_____

Did he/she ever receive antibiotics? _____ List the names: _____

_____

Any other medication for any other reason? _____

When did the parents notice the first anaphylactic symptoms or incident? _____

Was he/she hospitalized for it? _____ How often did he/she go to the hospital? _____

What tests were done? _____

Pediatrician? _____ Name? _____

Emergency room doctor? _____

What item or items did he/she have anaphylaxis with? _____

Total number of times he/she have anaphylactic reactions: _____

What other symptoms does he/she have? _____

Has he/she … ?

_____ Walked alone _____ Talked _____ Been toilet trained for bladder and bowel

_____ Enrolled in school _____ Been on any medication

_____ Had any reaction to medication _____ Taken any antibiotics and drugs

_____ Had/ Have a parasitic infestation _____ Visited other countries

Medical History:

_____ Surgeries

_____ Hospitalizations

_____ Diseases

_____ Frequent colds

_____ Fevers

_____ Ear infections

_____ Asthma

_____ Hives

_____ Bronchitis

_____ Pneumonia

_____ Seizures

_____ Sinusitis

_____ Headaches

Illnesses during early infancy:

_____ Colic

_____ Constipation

_____ Diarrhea

_____ Feeding problem

_____ Excessive Vomiting

_____ Excessive white coating on tongue

_____ Excessive crying

_____ Poor sleep

_____ Disturbed sleep

_____ Frequent ear infection

_____ Frequent fever

_____ Immunizations

_____ Response to the immunizations

_____Common childhood diseases like measles, chicken pox, mumps, strep throat, etc.

_____ Any other unusual events (fire in the house, accidents, earthquakes, etc.)

Is he/she attending school now? _____

Attending regular school? _____ Home schooling? _____

If the child has any skin problem along with anaphylactic history:

Any photo taken treatments? _____ Recent photo? _____

Please write a short summary of the child's early life (good and bad memories) from birth until present day?

Parent consent signature: Date: