Rowan Medicine

Pediatric New Patient Form

What is your relationship to the patient?	☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Other relative ☐ Guardian

Besides you, does anyone else take care of the child?

- ☐ Yes
- ☐ No

If yes, who? :

Who is the primary care provider for the child?

How many times has the child moved in the last year?

Where is the child living now?

- ☐ House or apartment with family
- ☐ House or apartment with relatives or friends
- ☐ Shelter
- ☐ Other

If "other", please describe:

Where else has your child received healthcare?

List medications: prescribed, over-the-counter and natural remedies. Please include strength and dosing.

Drug/medication allergy: Please list both the drug and describe the reaction that the child had.

Has the child had immunizations?

- ☐ Yes
- ☐ No

Where?

Do you have a copy of the immunization record?

- ☐ Yes
- ☐ No

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Has the child been Hospitalized? Please list reason and approximate age. If no hospitalizations, please enter none.

Has the child had any Surgeries? Please list reason and approximate age. If no surgeries, please enter none.

Do you have any concerns about behaviors at home, daycare, school?

- ☐ Yes
- ☐ No

What are your main concerns about your child?

How would you rate this child's health, in general?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Does the child's mother, father, grandparents or siblings have any of the following?

High blood pressure

- ☐ Yes
- ☐ No

Lung problems, like asthma

- ☐ Yes
- ☐ No

Heart problems

- ☐ Yes
- ☐ No

Learning problems

- ☐ Yes
- ☐ No

Nerve problems

- ☐ Yes
- ☐ No

Anxiety or Depression

- ☐ Yes
- ☐ No

Diabetes

- ☐ Yes
- ☐ No

Drinking or Drug problems

- ☐ Yes
- ☐ No

Please help us by answering the following child safety questions.

How often does the child use a seatbelt/carseat?

- ☐ Always
- ☐ Never
- ☐ Often
- ☐ Rarely
- ☐ Sometimes

Does your child ride a bicycle?

- ☐ Yes
- ☐ No

If yes, how often does he/she use a helmet?

- ☐ Always
- ☐ Never
- ☐ Often
- ☐ Rarely

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Do you feel that you live in a safe place? ☐ Yes ☐ No	**In the past year, have you ever felt threatened in your home?** ☐ Yes ☐ No
Do you feel that you live in a safe place? ☐ Yes ☐ No	**In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you or threatened to hurt you?** ☐ Yes ☐ No
What kinds of guns are in your home? ☐ Handgun ☐ Shotgun ☐ Rifle ☐ None	If you have a gun in your home, is it locked up? ☐ Yes ☐ No
Does anyone in your household smoke? ☐ Yes ☐ No	
Your answers here are kept strictly confidential as part of your child's medical record	
In the past year have you ever had a drinking problem? ☐ Yes ☐ No	**Have you tried to cut down on alcohol in the last year?** Yes No
How many drinks does it take for you to get high or get a buzz?	**Have you ever had a drug problem?** ☐ Yes ☐ No
Have you ever had a drug problem? ☐ Yes ☐ No	**Have you used any drugs in the last 24 hours?** ☐ Yes ☐ No
If yes, which ones? ☐ Cocaine ☐ Heroin ☐ Speed ☐ Marijuana ☐ Other	**Are you in a drug or alcohol recovery program now?** ☐ Yes ☐ No