Children's Medical Group of Austin, PLLC
New Patient History

Name _____ **DOB** _____

Birth History

Birth Weight _____

Hospital/City _____ Length of Stay _____

Problems/Complications _____

_____

Past Hospitalizations

Reason _____ Length of Stay _____Date/Age _____

Reason _____ Length of Stay _____Date/Age _____

Reason _____ Length of Stay _____Date/Age _____

Past Surgeries _____

_____

Medical Problems _____

_____

_____

Current Medications-taken regularly _____

_____

Allergies-please list allergy and reactions _____

_____

_____

Who may we thank for your referral? _____

Children's Medical Group

Has your child ever had any of the following:

___ Asthma/Bronchitis/Pneumonia
___ Frequent ear infections
___ Heart Problems/Murmurs
___ Seizure
___ Loss of Consciousness or Head Injury
___ Bladder or Kidney Infection
___ Broken bones (Age/Date _____)

Does anyone in your immediate family have the following:

___ Asthma or frequent bronchitis
___ Severe Allergies
___ Heart Problems (less than 50 yrs. of age)
___ Juvenile or Insulin Dependent Diabetes
___ Seizures of other neurologic disorders
___ Malignancy or Cancer
___ Thyroid disorder
___ Attention Deficit Disorder or learning disorders
___ Kidney disorders
___ Stomach or bowel disorders

Tell us about your home

Number of Adults _____ Relationship to child and occupation _____

_____

Siblings and Age _____

_____

Number of Smokers _____ Pets _____ Indoor Outdoor

Secondary home if applicable

City/State _____

Number of Adults _____ Relationship to child and occupation _____

Siblings and Age _____

_____

Number of Smokers _____ Pets _____ Indoor Outdoor

_____ _____

Patient's Name **Date of Birth**

_____ _____

Signature of Parent/Guardian **Date**