Walla Walla Clinic
Department of Pediatrics
55 W Tietan St.
Walla Walla, WA 99362 (509) 525-3720

New Patient History

Patient's Legal Name: Nickname: Birth Date: Sex: M / F

BIRTH:
Birth Weight: _____
Problems During Pregnancy - Y / N. If yes, _____
Problems During Labor/Delivery - Y / N. If yes, _____
Delivery - Vaginal or C-Section. If C-section, why _____
Problems with Patient as Newborn - Y / N. If yes, _____

NUTRITION:
Infants: Breast fed / Bottle fed / Both.
Child/Teen: Unlimited / Vegetarian / Vegan / Other _____
Food Intolerances: Y / N. If yes, _____
Vitamins and/or Fluoride? _____

DEVELOPMENT:
Speech or Developmental Concerns - Y / N. If yes _____
_____

MEDICAL:
Prior hospitalizations - Y / N. If yes, _____
Prior surgery - Y / N. If yes, _____
Current Medications - Y / N. If yes, _____
Allergies to Medications - Y / N. If yes, _____

Has this Patient ever had any of the following?

ADHD	Y / N	Frequent Belly Pain	Y / N
Allergies/Hayfever	Y / N	Heart Problems	Y / N
Anemia	Y / N	Head Injuries	Y / N
Asthma/Wheezing	Y / N	Hepatitis	Y / N
Back Pain/Deformity	Y / N	Jaundice	Y / N
Chest Pain	Y / N	Joint Pain/Swelling	Y / N
Chicken Pox	Y / N	Limb Pain/Deformity	Y / N
Chronic Cough	Y / N	Meningitis/Encephalitis	Y/ N
Chronic Fatigue	Y / N	Problems with Periods	Y / N
Concussion	Y / N	Age at first period	Y / N
Croup	Y / N	Pneumonia/Bronchitis	Y / N
Dental Problems	Y / N	Recent Weight Loss	Y / N
Eye/Vision Problems	Y / N	Recent Weight Gain	Y / N
Fainting Spells	Y / N	Seizures	Y / N
Fever Higher than 105	Y / N	Sinus Infections	Y / N
Frequent Constipation	Y / N	Short Attention Span	Y / N
Frequent Diarrhea	Y / N	Strep Throat	Y / N
Frequent Ear Infections	Y / N	Urinary Tract Infection	Y / N
Frequent Headaches	Y / N	Whooping Cough	Y / N
Frequent Nausea/Vomiting	Y / N	Other	Y / N
Frequent Sore Throat	Y / N		

SPECIALISTS:
List any specialists (other physicians, physical therapists, counselors, etc.) who care for this child. _____
_____
_____

IMMUNIZATIONS - VERY IMPORTANT
Please bring your child's vaccine record to the visit.

SOCIAL:
Patient lives with (circle): Natural Father, Natural Mother, Stepfather, Stepmother, Adoptive Parents, Grandparents, Guardian, other.
Names: _____
Other people who care for this Patient: _____
_____
Smoking in the home - Y / N.
Guns in the home - Y / N. If yes, secured by _____
School & Grade: _____
Favorite Activities & Interests:_____
Any significant adverse life events such as parental divorce, death of a parent, homelessness,exposure to abuse, etc.? Y / N.
If yes, _____

PSYCHOLOGICAL:
School Performance Concerns - Y / N. If yes, _____
Sleeping Problems - Y / N. If yes, _____
Drug/Alcohol/Tobacco Use - Y / N. If yes, _____
Nervous Tics/Habits - Y / N. If yes, _____
Anxiety/Depression/Behavior Concerns - Y / N. If yes,_____
_____

FAMILY HEALTH:
Natural Father: Name _____Wt_____
Medical Problems - Y / N. If yes. _____
Natural Mother: Name _____Wt _____
Medical Problems - Y / N. If yes. _____

Siblings

Name_____	Birthdate_____	Sex____	Health____
Name_____	Birthdate_____	Sex____	Health____
Name_____	Birthdate_____	Sex____	Health____
Name_____	Birthdate_____	Sex____	Health____
Name_____	Birthdate_____	Sex____	Health____

Is there a Family History of Any of the Following?
If so, Please Indicate Relationship to Patient:

Allergies	Y / N	
Alcohol/Drug Problems	Y / N	
Anemia/Blood Disease	Y / N	
Anxiety	Y / N	
Asthma	Y / N	
Cancer (type)	Y / N	
Depression, Bipolar, other	Y / N	
Diabetes Type I / Type II	Y / N	
GI Problems/Reflux	Y / N	
Heart Problems	Y / N	
Headache / Migraine	Y / N	
High Blood Pressure	Y / N	
Kidney Disorders	Y / N	
Seizures	Y / N	
Sudden, unexpected death	Y / N	
Thyroid Problems	Y / N	
Other	Y / N	

Today's Date: _____