Children's Physician Group

New Patient Form

Children's Healthcare of Atlanta

Your child has been referred to Children's Physician Group. **Please fill out this form and bring it to your child's appointment**. This information is confidential unless your sign a release form. Please print clearly and carefully.

Background Information			
Child's Name:	**Birthday:**	**Age:**	☐ **Male** ☐ **Female**
Mom's Name:	**Dad's Name:**		
Guardian's Name:			
Address:			
City:	**State:**	**Zip:**	
Home Phone:	**Mom's Work:**	**Mom's Cell:**	
Ok to leave a voicemail? ☐ **Yes** ☐ **No**	**Dad's Work:**	**Dad's Cell:**	
	Mom's Email:	**Dad's Email:**	

Reason for Visit	
Referring Physician:	**Pediatrician:**
Why are you seeing us today?	
What problem is your child having now?	
When did the problem start?	
Have you been given a diagnosis?	
Has your child had any tests?	
Has your child had any treatments?	
Who else have you seen for this problem?	
Provider Notes	

Questions for our Team
Question:
Question:
Question:
Question:
Question:
Question:
Question:

Birth History		
Birth Weight:	**Birth Length:**	**Vaginal ☐ C-Section ☐**
Was your child born premature? ☐Yes ☐No	**Gestational Weeks:**	**Length in hospital?**
Were there any abnormalities on the newborn screening? ☐Yes ☐No ☐ Unknown		**Born in U.S.?** ☐Yes ☐No
Any fetal exposure to drugs, tobacco or alcohol? ☐Yes ☐No ☐Unknown		
Any problems during pregnancy? ☐Yes ☐No What problems?		
Did your baby require any special care? ☐Yes ☐ No What kind of care?		
You do not need to fill in the information in the two rows below. However, it may help in the diagnoses of certain diseases.		
Child's Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino		
Child's Race: ☐African American/Black ☐White ☐Asian ☐Pacific Islander ☐American Indian/Alaskan		
Provider Notes		

Past Medical History: Does your child have any problems with:		
Heart	☐Yes ☐No	**Explain:**
Lungs/Asthma	☐Yes ☐No	**Explain:**
Stomach/Bowels	☐Yes ☐No	**Explain:**
GERD/Reflux	☐Yes ☐No	**Explain:**
Kidneys	☐Yes ☐No	**Explain:**
Urinary Tract	☐Yes ☐No	**Explain:**
Muscles/Joints	☐Yes ☐No	**Explain:**
Skin	☐Yes ☐No	**Explain:**
Eyes/Vision	☐Yes ☐No	**Explain:**
Diabetes/Thyroid	☐Yes ☐No	**Explain:**
Allergies/Immune	☐Yes ☐No	**Explain:**
Infections	☐Yes ☐No	**Explain:**
Brain/Head	☐Yes ☐No	**Explain:**
Weight loss, Fever	☐Yes ☐No	**Explain:**
Emotions	☐Yes ☐No	**Explain:**
Other	☐Yes ☐No	**Explain:**

List names and reasons for any antibiotics taken in the past 12 months:
List names of any steroids taken in the past 12 months:
Home medical equipment/oxygen ☐ Yes ☐ No What:
Home care company name and phone:
Provider Notes

Surgical/Hospitalization History	
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Provider Notes	

Birth Mother:	Age:	Height:	Current Health:
Birth Father:	Age:	Height:	Current Health:

Condition		None	Father	Mother	Sibling	Paternal Grandparents	Maternal Grandparents
Asthma	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Hay Fever	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Eczema	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Food Allergies	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Environmental Allergies	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Sinus Infections	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Bronchitis	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Low Immunity	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Heart Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Cystic Fibrosis	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Birth Defects	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Down syndrome	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Mood Disorder	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Depression	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Anemia	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Bleeding Disorder	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
High Blood Pressure	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Cancer or Leukemia	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Low Blood Pressure	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Inflammatory Bowel	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Immunologic Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Gastroesophageal Reflux	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Celiac Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Joint Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Cerebral Palsy	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Liver Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Kidney Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Thyroid Disease	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*
Seizure Disorder	☐Yes ☐No	*N*	*F*	*M*	*S*	*PG*	*MG*

Provider Notes

Social History	
Mother's job:	Is your child in daycare? ☐Yes ☐No
Father's job:	Is your child in school? ☐Yes ☐No What Grade:
Who are the adults in the home?	Your child's grades: ☐A's ☐B's ☐C's ☐Failing
	Is your child missing school? ☐Yes ☐No How many days has he missed this term?
Who are the children in the home? (List ages)	Does your child take part in PE? ☐Yes ☐No
	Does your child take part in after school sports? ☐Yes ☐No Which sports?
Smoking in the home? ☐Yes ☐No	What does your child like to do outside of school?
Pets in the home? ☐Yes ☐No Type:	
Around animals? ☐Yes ☐No Type:	
Recent life changes? ☐Yes ☐No Type:	

Provider Notes

Patient Questions (Have your child circle the best answers if he is over 8 years old.)										
1 = I feel very bad, 10 = I feel very good										
How did you feel overall during the past week?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How did you feel overall during the past month?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is the best you have felt in your life?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Parent Questions (circle the best answers)										
1 = You think your child feels very bad, 10 = You think your child feels very good										
How did your child feel during the past week?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How did your child feel during the past month?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is the best your child has ever felt?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

During the past month, has your child had any of the following?

General

Feels healthy	☐ Yes	☐ No
Lowered energy	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight gain/loss	☐ Yes	☐ No

Other:

Eyes

Glasses or contacts	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Light sensitivity	☐ Yes	☐ No
Yellow or red eyes	☐ Yes	☐ No

Other:

Ears, Nose, Throat (ENT)

Many infections	☐ Yes	☐ No
Trouble hearing	☐ Yes	☐ No
Ear pain	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No

Other:

Lungs

Wheezing	☐ Yes	☐ No
Coughing	☐ Yes	☐ No
Asthma attack	☐ Yes	☐ No
Trouble breathing	☐ Yes	☐ No
Rescue inhaler use	☐ Yes	☐ No
Turning blue	☐ Yes	☐ No
Home oxygen use	☐ Yes	☐ No

Other:

Heart

High blood pressure	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Limb swelling	☐ Yes	☐ No
Fast/slow heartbeat	☐ Yes	☐ No
Unable to exercise	☐ Yes	☐ No

Other:

Digestive

Appetite changes	☐ Yes	☐ No
Stomach aches/pains	☐ Yes	☐ No
Feeding/choking problems	☐ Yes	☐ No
Heartburn/reflux	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Other:

Urinary/Genital

Daytime wetting	☐ Yes	☐ No
Nighttime wetting	☐ Yes	☐ No
Pain on urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Sores	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Menstruation	☐ Yes	☐ No

Other:

Skin

Rashes	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Sores/wounds	☐ Yes	☐ No
Yellow skin (jaundice)	☐ Yes	☐ No
Itching	☐ Yes	☐ No

Other:

Muscles/Bones/Joints

Muscle pain/cramps	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Trouble walking	☐ Yes	☐ No
Uses assistive devices	☐ Yes	☐ No
New muscle weakness	☐ Yes	☐ No
Broken bone	☐ Yes	☐ No

Other:

Neurological

Headaches	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Concussion/trauma	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Other:

Behavioral/Emotional

Sad	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Avoiding school	☐ Yes	☐ No
Aggressive tendencies	☐ Yes	☐ No
Bullying victim	☐ Yes	☐ No
Forgetfulness	☐ Yes	☐ No

Other:

Endocrine

Excessive hunger	☐ Yes	☐ No
Excessive urination	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Too short	☐ Yes	☐ No
Too tall	☐ Yes	☐ No
Overweight	☐ Yes	☐ No

Other:

Allergic/Immunologic

Food intolerances	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No
Allergy testing	☐ Yes	☐ No
Hives	☐ Yes	☐ No

Other:

Blood/Lymph

Easy bruising	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No
Lumps on the body	☐ Yes	☐ No
Sickle cell crisis	☐ Yes	☐ No

Other:

Other concerns

Please list all food and drinks your child had in the past 24 hours. (List the amount)

Breakfast:

Lunch:

Dinner:

Snacks:

Provider Notes

Allergies					
Medicine Allergies: ☐No ☐Yes List:					
Food Allergies: ☐No ☐Yes List:					

Medicines

List the name of each medicine your child takes	**How much does your child take?**	**How often is it supposed to be taken?**	**How does your child take this medication?**	**Why does your child take this medication?**	**How often did your child take the medicine last week?**
Example: Prevacid	***15 mg***	***once a day***	***by mouth***	***for reflux***	☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day
					☐ Not at all ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Every day

Who filled out this form? ☐ Patient ☐ Parent ☐ Guardian ☐ Other: ____________________

I have reviewed the list above and to the best of my knowledge, these are the medicines that the patient is currently taking.

Signature (Parent/Guardian/Patient) ________________________ **Signature (Provider)** ________________________ **Date/Time** __________

Preferred Pharmacy: ____ **Phone:** ________________________

OFFICE USE ONLY BEYOND THIS POINT

Screening							
Vital Signs							
Temp:	**HR:**	**RR:**	**BP:**	**SpO2:** ☐**RA** ☐**O2**	**Ht:_____cm** _____%ile	**Wt:_____kg** _____%ile	**BMI:** _____**kg/m^2**
Pain Score /10	**Scale:** Numeric, FACES, FLAAC		**Quality:** ☐Chronic ☐Intermittent ☐Acute ☐Constant			**Location**:	**Duration:**
Are immunizations up to date? ☐Yes ☐Not sure ☐Missing doses ☐ Do not immunize							
Recent disease exposure? ☐Yes ☐No, if yes ☐Measles ☐Strep ☐Chicken Pox ☐Other:							
Do they have any of the following? ☐MRSA ☐VRE ☐Cepacia ☐Other:							
Has child or family traveled outside of the U.S. in the last month? ☐Yes ☐No Where?							
Is it okay to leave a message on voicemail? ☐Yes ☐No							
How often do you need help with written instructions/materials from doctor or pharmacy? ☐ Never ☐ Sometimes ☐ Often ☐ Always							
I provided patient/family with information on safety initiatives. ☐Yes ☐No							
Signature:							**Date:**