Boca VIPediatrics™

Chad A. Rudnick, M.D.

New Patient Medical History Form

Date	Child's Name	Nickname	DOB	SSN	(Circle) M F

Previous Pediatrician/Office (if applicable)	Date of last physical	Request For Records Transfer From Previous Doctor Yes No

Parent Name(s)	Occupation(s)	Parent Age(s)

Home Address	City	State	Zip	Home Phone: Cell Phone:

Insurance Carrier	Policy #	Group #

Emergency Contact Name	Address	Phone	Relationship to Patient

In my absence, I hereby authorize Chad A. Rudnick, M.D. and/or his associates to provide all medical care necessary for the welfare of my children. Informed consent is hereby given for any and all procedures necessary for treatment in which there may be un-foreseen effects.

I have read and understand the above.

Parent or Legal Guardian: _____ Date: _____
(Signature)

Print: _____

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Birth History

Birth Weight: _____ Pregnancy # _____ Mom's age at time of birth: _____

How many weeks gestation was the pregnancy? _____ Delivery: ☐ Vaginal ☐ Cesarean

Did mother have any illness or problems with her pregnancy? ☐ Yes ☐ No

If yes, explain: _____

Did your baby have any problems right after birth? ☐ Yes ☐ No

If yes, explain: _____

During pregnancy, did mother:

Smoke: ☐ Yes ☐ No Drink alcohol: ☐ Yes ☐ No

Use drugs or medications: ☐ Yes ☐ No

If yes, which: _____

Current and Past History

Use back side for more space

Is your child currently on any medication?	Y N Explain _____
Does your child have any serious or chronic illnesses?	Y N Explain _____
Has your child had serious injuries or accidents?	Y N Explain _____
Has your child had any surgery?	Y N Explain _____
Has your child ever been hospitalized?	Y N Explain _____
Is your child allergic to any medicine or drugs?	Y N Explain _____
Has your child had any reactions to immunizations?	Y N Explain _____
Does Your Child Have, or Ever Had:	
Asthma, recurrent cough, bronchitis, or pneumonia	Y N Explain _____
Nasal allergies or eczema	Y N Explain _____
Frequent ear infections or sore throats	Y N Explain _____
Problems with ears or hearing	Y N Explain _____
Problems with eyes, vision, or teeth	Y N Explain _____
Frequent headaches or other neurologic problems	Y N Explain _____
Frequent abdominal pain	Y N Explain _____

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Constipation requiring doctor visits	Y N Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old)	Y N Explain _____
Any heart problem or heart murmur	Y N Explain _____
Anemia or bleeding problem	Y N Explain _____
Thyroid or other endocrine problem	Y N Explain _____
Diabetes	Y N Explain _____
ADHD	Y N Explain _____
Mental health issues (i.e. anxiety, depression)	Y N Explain _____
Use of alcohol or drugs	Y N Explain _____

Any other medical or mental health issues/problems

_____

Does your child see any specialists? Y N If yes, who? _____

For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, and/or Speech Therapy? Y N

If yes, for what reason or diagnosis? _____

What grade is your child in school? (if applicable) _____

Are they in special or resource classes in school? Y N Explain _____

Do you have any other issues of concerns not listed above? _____

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Household Information

Please list all those living in the child's home

Name	Relationship to Child	Date of Birth

Is the child in daycare: _____

Smokers in the household? (inside or outside): ☐ Yes ☐ No Pets in household? ☐ Yes ☐ No Type:_____

Are there siblings not listed above? If so, please list their names, ages, and where they live. _____

If mother and father are not living together or if the child does not live with parents, what is the child's custody status?

_____

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Family Medical History (Parents, Siblings, Grandparents, Aunts, Uncles, First Cousins)

Have any family members had the following?

Allergies	Y	N	Who:_____
Anesthesia Risk	Y	N	Who:_____
Arthritis	Y	N	Who:_____
Blood Disease	Y	N	Who:_____
Cancer	Y	N	Who:_____
Diabetes	Y	N	Who:_____
Genetic	Y	N	Who:_____
Gastroenteritis	Y	N	Who:_____
Genitourinary	Y	N	Who:_____
Heart	Y	N	Who:_____
High Blood Pressure	Y	N	Who:_____
Cholesterol	Y	N	Who:_____
Neurologic Diagnosis	Y	N	Who:_____
Psychiatry	Y	N	Who:_____
Eye Problems	Y	N	Who:_____
Respiratory	Y	N	Who:_____
Skin	Y	N	Who:_____
Stroke	Y	N	Who:_____
Thyroid	Y	N	Who:_____
Drug Abuse	Y	N	Who:_____

Additional family history or comments: _____

_____

_____

How did you hear about Boca VIPediatrics? _____

_____

_____

For office use only: