Trinity Medical WNY

New Patient Information/Child

PATIENT INFORMATION:

Patient Name: ______________________ **Sex:** M F **Date:** ______________

Birthdate: ______________________ **Ethnicity:** ( ) White ( ) Black/African American ( )Asian ( ) Native Hawaiian/Other Pacific Islander ( ) Other ( ) Decline/Unknown

Name of Person Filling Out Form: ______________________

Relation To Child: ______________________ **Race:** ( ) Spanish/Hispanic ( ) Not of Spanish/Hispanic origin ( )Decline/Unknown

Address: ______________________

Home #: ______________

Work#: ______________

Cell #: ______________

Prior Medical Provider: ______________________

Mother's Maiden Name: ______________________ **Primary Language:** ______________

Pharmacy: ______________________ **Pharmacy address:** ______________

Pharmacy Phone #: ______________________

BILLING INFORMATION:

Primary		**Secondary**	
Insurance Co:		**Insurance Co:**	
Policy Holder:		**Policy Holder:**	
Policyholder DOB:		**Policyholder DOB:**	
ID#:		**ID#:**	
Group #:		**Group #:**	

PAST HISTORY

Pregnancy Complications: ______________________

Delivery: ( ) Vaginal ( )Caesarian

Birth Weight: ______________ **Length of Stay in Hospital**______**Days**

Birth History: ( )Term (37-40 weeks) ( ) Premature (less than 37 weeks) ( )Post Term (more than 42 weeks)

Complication at Birth or two weeks of life: ______________________

HOSPITALIZATIONS ( )Never ( )Overnight ( )1-3 times ( )More than 3 times

Please list the following information:

	Illness	**Month and Year**	**Hospital and City**
1			
2			
3			

SURGERIES- Please list any surgeries your child has had:

Type of surgery: ______________________ **Date:** ______________

MEDICAL Please check if your child has had any of the following:

( )Chicken Pox	( )Mononucleosis	( )Exposed to Tuberculosis	( ) Diabetic ( ) Type 1 ( ) Type 2
( )Hay Fever	( )Hives	( )Bladder/Kidney Infections	( ) Hypertention
( )Asthma/Wheezing	( )Pneumonia	( )Fainting/Syncope	( ) Thyroid Problems
( )Elevated Lead	( )Anemia/Blood Problems	( )Eczema/Skin Rashes	( ) Cancer Type: ______
( )Yellow Jaundice	( )Broken Bones	( )Heart Murmur/Heart Disease	( ) Dizziness/Vertigo
( )Seizures	( )Severe Burns	( )Concussion or Head injury	( ) Depression/Anxiety

Other illnesses (please list): ______________________

MEDICATIONS: Please list all medications, non-prescription medications, and vitamins your child is now taking

Medicine or Vitamin	**Dose(How Much)**	**Frequency(How often)**

ALLERGIES: Does your child have any allergies to any medication or food?

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Trinity Medical WNY

FAMILY HISTORY

PRINT NAME OF CHILD'S RELATIVE, LIVING OR DECEASED AND YEAR OF BIRTH	FIRST LAST NAME	Year of Birth	ALLERGIES	ASTHMA	BLEEDING TENDENCY	CANCER	DIABETES	EPILEPSY	SUDDEN DEATH/UNKNOWN CAUSE	MENTAL RETARDATION	HIGH BLOOD PRESSURE	KIDNEY DISEASE/BLADDERINFECTION	DEPRESSION/ANXIETY/MENTAL ILLNESS	RHEUMATISM/ARTHRITIS	ULCER/ GI PROBLEMS	STROKE	TUBERCULOSIS	BIRTH DEFECTS	HEART DISEASE	HIGH CHOLESTEROL	HIP DYSPLASIA	DEATHS If relative listed has died, list cause and age of death	AGE
FATHER																							
MOTHER																							
BROTHER and/or SISTER																							
GRAND-PARENTS																							

OTHER FAMILY ILLNESS (PLEASE LIST) ______________________________

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HABITS

YES	NO	
[ ]	[ ]	Uses seat belt or child seat regularly
[ ]	[ ]	Trouble with vision
[ ]	[ ]	Ever had eye exam
[ ]	[ ]	Had dental exam within past year
[ ]	[ ]	Brushes teeth daily
[ ]	[ ]	Frequent colds
[ ]	[ ]	Frequent sore throats
[ ]	[ ]	Frequent ear infections
[ ]	[ ]	Frequent diarrhea or constipation
[ ]	[ ]	Frequent vomitting,stomach pains
[ ]	[ ]	Joint/muscle pain,swollen or red joints
[ ]	[ ]	Rashes

YES	NO	
[ ]	[ ]	Trouble with hearing
[ ]	[ ]	Breathing problems or shortness of breath
[ ]	[ ]	Easily fatigues or tiredness
[ ]	[ ]	Feeding or eating problems
[ ]	[ ]	Bed wetting/painful or frequent urination
[ ]	[ ]	Easy bruising of bleeding
[ ]	[ ]	Severe or frequent headaches
[ ]	[ ]	Behavioral problems
[ ]	[ ]	Problems in school
[ ]	[ ]	Stress in family

OTHER INFORMATION THE DOCTOR SHOULD KNOW ______________________________

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RETURN TO ONE OF THE FOLLOWING OFFICES: **TRINITY MEDICAL WNY, PC -** 5879 Snyder Drive Lockport NY 14094