Weill Cornell Medicine
Dermatology

New Patient Medical History Form--Pediatrics

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or none if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:			Date of Visit:
Date of Birth:	Age:	***Home Phone:*** ***Other Phone:***	
Preferred Email:		Social Security Number:	
Address:		***Emergency Contact (Name and Number):***	
Guardian 1 Name/Phone Number: Relationship to Patient:		Guardian 2 Name/Phone Number: Relationship to Patient:	
PRIMARY INSURANCE CARRIER:		**INSURANCE ID #:**	
Does your insurance plan require referrals for specialty visits? ❑ Yes ❑ No		If **YES,** do you have a referral for today's visit? ❑ Yes ❑ No	

Physician and Pharmacy Information	
Pediatric Physician (Name/Phone/Fax Number):	**Preferred Pharmacy** (Name/Phone/Fax Number):
Referring Physician (Name/Phone/Fax): ❑ Same as Pediatrician	**Other Physician to send records to** (Name/Phone/Fax):
Specialty:	Specialty:

Reason/s For Visit:

Medical History		
Please include all medical problems even if not relevant to this visit. If no medical problems, write none.		
Current or Past Medical Problems	**Dates**	**Reasons**

Hospitalizations/Surgeries	**Dates**	**Reason**

Medications/Supplements	**Dosage/Frequency**	**Condition/Reason**

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

Birth History		
Birth Weight:	Full Term: ❑ Yes ❑ No	If not full-term, gestational age at birth (weeks):

Family History				
Has anyone in the patient's family had any of the following?				
Heart disease or stroke	❑ Parent	❑ Sibling	❑ Other Relative	
Hypertension	❑ Parent	❑ Sibling	❑ Other Relative	
Diabetes	❑ Parent	❑ Sibling	❑ Other Relative	
High cholesterol	❑ Parent	❑ Sibling	❑ Other Relative	
Gastrointestinal problems	❑ Parent	❑ Sibling	❑ Other Relative	Describe:
Cancer	❑ Parent	❑ Sibling	❑ Other Relative	Type:
Respiratory problems	❑ Parent	❑ Sibling	❑ Other Relative	Describe:
Neurological problems	❑ Parent	❑ Sibling	❑ Other Relative	Describe:
Vision problems	❑ Parent	❑ Sibling	❑ Other Relative	Describe:
Development delays	❑ Parent	❑ Sibling	❑ Other Relative	Describe:

Social History		
School Age/Grade:	**Exposed to Second-Hand Smoke:** ❑ Yes ❑ No	**Sunscreen Use:** ❑ Yes ❑ No
Patient Lives With: ❑ Both Parents ❑ One Parent ❑ Other: _____		
Does your child suffer from ADHD and/or depression and anxiety? ❑ Yes ❑ No Please describe:		

Date of most recent flu shot (age 6 months+):	Immunizations up to date: ❑ Yes ❑ No

How did you hear about us?
❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertisement ❑ Referral Service ❑ Weill Cornell Connect ❑ Int'l Office

The information is accurate and complete to the best of my knowledge. *I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.*	
Guardian Signature: Name of person completing form (if not patient): Signature:	Physician Signature: Today's Date:

Today's Date:	

Review of Systems

Please check 'YES' or 'NO' for EACH item

Constitutional
❑ Normal
Y N
❑ ❑ Fever
❑ ❑ Chills
❑ ❑ Night sweats
❑ ❑ Weight loss/gain
❑ ❑ Sleep disturbance
❑ ❑ Fatigue
❑ ❑ Poor appetite

Eyes
❑ Normal
Y N
❑ ❑ Contact lenses or glasses
Type: _____
❑ ❑ Blurry vision
❑ ❑ Glaucoma
❑ ❑ Cataracts
❑ ❑ Retinal detachment
❑ ❑ Macular degeneration
❑ ❑ Blindness
❑ ❑ Redness
❑ ❑ Tearing
❑ ❑ Dryness
❑ ❑ Double Vision
❑ ❑ Discharge
❑ ❑ Pain

Ear
❑ Normal
Y N
❑ ❑ Hearing loss
❑ ❑ Hearing aids
❑ ❑ Wax
❑ ❑ Ear pain
❑ ❑ Ringing/noise/tinnitus
❑ ❑ Previous ear surgery
❑ ❑ Loud noise exposure

Respiratory
❑ Normal
Y N
❑ ❑ Asthma
❑ ❑ Emphysema/COPD
❑ ❑ Bronchitis
❑ ❑ Pneumonia
❑ ❑ Aspiration
❑ ❑ Tracheotomy
❑ ❑ Tuberculosis
❑ ❑ Coughing blood
❑ ❑ Shortness of breath
❑ ❑ Wheezing
❑ ❑ Cough over 3 months

Nose
❑ Normal
Y N
❑ ❑ Congestion
❑ ❑ Mucus
❑ ❑ Post nasal drip
❑ ❑ Sinus infection
❑ ❑ Sinus headaches
❑ ❑ Nose Bleeds

Allergy
❑ Normal
Y N
❑ ❑ Sneezing
❑ ❑ Runny Nose
❑ ❑ Itchy ears, eyes, or nose
❑ ❑ Transplant
❑ ❑ Hives

Throat
❑ Normal
Y N
❑ ❑ Voice problems
❑ ❑ Swallowing problems
❑ ❑ Throat Pain
❑ ❑ Phlegm
❑ ❑ Feeling of something stuck
❑ ❑ Tonsil infections/problems

Sleep
❑ Normal
Y N
❑ ❑ Snoring
❑ ❑ Sleep Apnea
❑ ❑ CPAP/BiPAP/AutoPAP
❑ ❑ Insomnia
❑ ❑ Choking/Gasping
❑ ❑ Restless leg
❑ ❑ Daytime sleepiness

Endocrine
❑ Normal
Y N
❑ ❑ Diabetes
❑ ❑ Thyroid problems
❑ ❑ Autoimmune disease
Type: _____
❑ ❑ Immune deficiency
❑ ❑ Excessive thirst
❑ ❑ Swollen lymph nodes
❑ ❑ Cold/heat intolerance
❑ ❑ Gout

Gastrointestinal
❑ Normal
❑ ❑ Diarrhea
❑ ❑ Constipation
❑ ❑ Blood in stool
❑ ❑ Vomiting/nausea
❑ ❑ Ascites
❑ ❑ Heartburn/acid reflux
❑ ❑ Abdominal pain
❑ ❑ Gallstones
❑ ❑ Pancreatitis
❑ ❑ Jaundice

Neurologic/Neuromuscular
❑ Normal
Y N
❑ ❑ Headaches/migraines
❑ ❑ Encephalopathy
❑ ❑ Seizures
❑ ❑ Tremors
❑ ❑ Numbness
❑ ❑ Stroke
❑ ❑ Imbalance/vertigo
❑ ❑ Lightheaded/fainting
❑ ❑ Memory loss
❑ ❑ Unexplained weakness

Hematologic
❑ Normal
Y N
❑ ❑ Bruise easily
❑ ❑ Anemia
❑ ❑ Leukemia/Lymphoma
❑ ❑ Blood clots
❑ ❑ Bleeding disorders
❑ ❑ History of radiation

Oral/Dental
❑ Normal
Y N
❑ ❑ Dentures/implants
❑ ❑ Temporomandibular joint
❑ ❑ Teeth clenching/grinding
❑ ❑ Tongue problems
❑ ❑ Mouth lesions

Genitourinary
❑ Normal
Y N
❑ ❑ Frequent urination
❑ ❑ Prostate problems
❑ ❑ Urine/bladder infections
❑ ❑ Yeast infections
❑ ❑ Incontinence
❑ ❑ Kidney problems/stones

Skin
❑ Normal
Y N
❑ ❑ Past skin cancer
Type: _____
❑ ❑ Skin biopsy
Site: _____
❑ ❑ Eczema
❑ ❑ Rash or skin sensitivity
❑ ❑ Abnormal skin moles
❑ ❑ History of skin disease
❑ ❑ Hair loss/growth
❑ ❑ Itching
❑ ❑ Keloid scars

Musculoskeletal
❑ Normal
Y N
❑ ❑ Neck pain
❑ ❑ Arthritis
❑ ❑ Back pain/spinal problems
❑ ❑ Fractures
❑ ❑ Muscle pain
❑ ❑ Swelling
❑ ❑ Joint/bone pain

Cardiovascular
❑ Normal
Y N
❑ ❑ Heart attack
❑ ❑ High blood pressure
❑ ❑ High cholesterol
❑ ❑ Stents
❑ ❑ Coronary artery disease
❑ ❑ Irregular heart beat
❑ ❑ Chest pains
❑ ❑ Leg swelling
❑ ❑ Pacemaker/defibrillator

Psychiatric
❑ Normal
Y N
❑ ❑ Anxiety
❑ ❑ Depression
❑ ❑ Bi-polar
❑ ❑ Psychosis

Male/Female Health
❑ Normal
Y N
❑ ❑ Abnormal periods
❑ ❑ Abnormal discharge
❑ ❑ Sore on penis
❑ ❑ Discharge from penis

Any other comments/problems/concerns: