UF Health Pediatrics – San Jose
New Patient Profile

Name	Date of birth

MEDICAL HISTORY

Birth Weight:			
Full term?	**Yes**	**No**	If premature how many weeks?
Complications? If yes, please list	Yes	No	
Medical Problems? Please check or circle	**Asthma/wheezing**		**Seizures**
	Chronic cough		**Eczema**
	Allergies		**Learning Difficulty**
	Diabetes		**Sleep problems**
	Anemia		**Developmental problems**
	ADHD		**Other**
	Autism		
	Hearing loss		
Hospitalizations? If yes – date, reason	**Yes**	**No**	
Surgery? If yes- date, reason	**Yes**	**No**	
Injury/Trauma? If yes- date, type	**Yes**	**No**	
Medications: If yes, List name & dose	**Yes**	**No**	
Previous Doctor:	**Name:**		**Last visit:** **N/A**
Dentist:	**Name:**		**Last visit:** **N/A**

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Vaccines:	**Up to date?** **Yes No N/A**	**Reactions to vaccines?** **Yes No N/A**
Allergies: If yes, list	**Medicines:** **Yes No N/A**	**Foods:** **Yes No N/A**
	Other:	

FAMILY HISTORY

Check or circle any conditions for child's parents, siblings, grandparents or other blood relatives	**Sickle cell**	**ADHD**
	Diabetes	**High blood pressure**
	Heart problems	**Tuberculosis**
	Anxiety/Depression	**Mental illness**
	Addiction/substance use	**Cancer**
	AIDS	**Arthritis**
	Allergies	**Anemia**
	Hearing loss/Deafness	**Lupus**
	Thyroid disease	**Asthma**
	Other:	

SOCIAL HISTORY

School?	**Name**	**Grade**	**N/A**
Daycare/Aftercare?	**Name**	**Hours per week**	**N/A**
Language at home	**English Spanish Other:**		

Who lives with child?	**Name**	**Age**	**Relation to child**

Safety	**Smokers at home? Yes No**	**Lead exposure? Yes No Not sure**
	Use seat belt/car seat? Yes No	**Bike helmet? Yes No N/A**
	Smoke detectors? Yes No	**Guns in home? Yes No**

Please add any additional information you would like us to know about your child:

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