General Information

Patient's full name:_____

Patient's date of birth:_____

Nickname:_____

Your relationship to patient:_____

Patient's previous doctor:_____

Current medications

Please include vitamins, supplements and herbs:

_____

_____

Allergies

☐ None

☐ Food:_____

☐ Seasonal:_____

☐ Other:_____

Pregnancy and Delivery

Where was patient born? (State and hospital): _____

_____

Is the patient yours by:

☐ Birth ☐ Adoption ☐ Stepchild

☐ Foster child ☐ IVF ☐ Donor egg

☐ Donor sperm ☐ Other_____

Pregnancy:

Any medications taken during pregnancy:

☐ None ☐ Prenatal vitamins

☐ Other_____

_____

Length of pregnancy:_____weeks

Please indicate any complications during pregnancy:

☐ None ☐ Spotting/Bleeding

☐ Preterm labor ☐ Threatened miscarriage

☐ High blood pressure ☐ Group B Strep positive

☐ Hepatitis B ☐ Herpes

☐ Gestational diabetes ☐ Preeclampsia/Toxemia

☐ Maternal Illnesses/Infections: _____

☐ Other_____

_____

_____

Number of Ultrasounds:___ ☐ Normal ☐ Abnormal

Describe any abnormalities:_____

Amniocentesis? ☐ Yes ☐ No Why and results?___

_____

Mother's blood type:_____Patient's blood type:___

Labor: ☐ Spontaneous

☐ Induction (Method and why?):_____

_____

Length of labor:_____

Delivery:

☐ Vaginal ☐ Caesarian Section ☐ Breech

Birth weight:_____Birth length:_____

Apgar scores:_____/_____

Please indicate any complications:

☐ None ☐ Prolonged delivery

☐ Vacuum assist ☐ Forceps

☐ Needed oxygen ☐ Needed resuscitation

☐ Jaundice ☐ Phototherapy

☐ Premature & how early?_____

☐ Admitted to NICU & why?_____

_____

Immunizations

Please bring a copy of your immunization record to your first appointment, or send it by mail or fax with this form.

☐ Immunizations current

☐ Behind on immunizations & why:_____

_____

☐ Not immunized & why:_____

_____

Family Social History

Patient's parents are:

☐ Married ☐ Separated

☐ Divorced ☐ Unmarried

☐ Domestic partners

☐ Mother is remarried ☐ Father is remarried

☐ Mother is deceased ☐ Father is deceased

If divorced or separated patient lives with whom?

☐ Mother ☐ Father ☐ Joint

Time with each parent:_____

Occupations:

Father's occupation:_____

Father's employer:_____

Mother's occupation:_____

Mother's employer:_____

Who lives at home with patient? (Include parents, siblings, grandparents, etc.)

Name Age Relationship

_____

_____

_____

_____

_____

_____

Past Medical History

☐ Current or previous medical diagnoses:_____

_____

_____

☐ Hospitalizations & why? (Include age or date):___

_____

_____

☐ Surgeries & why? (Include age or date):_____

_____

_____

☐ Injuries, fractures, stitches, etc:_____

_____

Development:

Smiling: ☐ On time ☐ Delayed

Laughs: ☐ On time ☐ Delayed

Sitting upright: ☐ On time ☐ Delayed

Crawling: ☐ On time ☐ Delayed

Pulls to a stand: ☐ On time ☐ Delayed

Imitates speech sounds:

☐ On time ☐ Delayed

Other developmental concerns:_____

_____

_____

Nutrition:

☐ Breast milk

How many feeds per day?_____

Minutes per feed?_____

☐ Formula

Type: ☐ Milk based ☐ Soy based

☐ Other:_____

Formula intake:_____ounces/day

Has your child started solids? ☐ Yes ☐ No

Has your child had any unusual dietary or feeding problems? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Sleep:

Hours per night:_____

Naps per day (Number & length):_____

Where does your child sleep?_____

Any sleep problems?_____

_____

Daycare:

☐ None ☐ Commercial center

☐ Relative ☐ In home provider

Name of current daycare:_____

Social Concerns:

☐ None ☐ Family issues

☐ Other:_____

If yes, please explain:_____

_____

_____

Activities/Exposures:

Number of hours per day of screen time (TV, computers, video games, etc.):_____

Exposure to smoking? ☐ Yes ☐ No

Exposure to guns? ☐ Yes ☐ No

If yes, are they locked up? ☐ Yes ☐ No

Review of All Systems: Please check any current or past medical problems your child has had.

General:

- ☐ Fever ☐ Excessive sweating
- ☐ Chills ☐ Unexplained weight loss
- ☐ Fatigue ☐ Unexplained weight gain

Eyes:

- ☐ Lazy eye(s) ☐ Crossed eyes
- ☐ Congenital cataracts ☐ Other:_____

Ears, Nose & Throat:

- ☐ Cleft lip ☐ Cleft palate
- ☐ Hearing loss ☐ Frequent ear infections
- ☐ Allergies ☐ Frequent runny nose
- ☐ Snoring ☐ Frequent bloody nose
- ☐ Problems with teeth and gums

Respiratory:

- ☐ RSV ☐ Chronic cough
- ☐ RAD or wheezing ☐ Recurrent croup
- ☐ Shortness of breath ☐ Cystic fibrosis
- ☐ Whooping cough (Pertussis)

Cardiovascular:

- ☐ Heart murmur ☐ Heart defect
- ☐ Fainting ☐ Arrhythmia
- ☐ Color change with feeds
- ☐ Sweating with feeds

Gastrointestinal:

- ☐ Nausea ☐ Constipation
- ☐ Chronic diarrhea ☐ Unexplained vomiting
- ☐ Blood in stools ☐ Frequent stomach aches
- ☐ Jaundice ☐ Umbilical hernia

Genitourinary:

- ☐ UTI ☐ Pain with urination
- ☐ Frequent urination ☐ Blood in urine
- ☐ Foul smelling urine ☐ Urinary reflux
- ☐ Hydrocele ☐ Hernia
- ☐ Hypospadius

Musculoskeletal:

- ☐ Hip dysplasia/Dislocated hip
- ☐ Club feet/foot ☐ Joint swelling
- ☐ Muscle weakness ☐ Increased muscle tone

Neurological:

- ☐ Cerebral palsy ☐ Fainting
- ☐ Seizures ☐ Breath holding spells
- ☐ Staring spells

Nutrition:

- ☐ Feeding difficulties ☐ Formula intolerance
- ☐ Breast milk colitis ☐ Overweight
- ☐ Underweight or poor growth

Developmental or Emotional:

- ☐ Developmental delay ☐ Speech problems
- ☐ Sleep difficulty ☐ Thumb sucking
- ☐ Fearful/Overly anxious

Skin:

- ☐ Eczema ☐ Birth marks
- ☐ Unusual moles ☐ Rashes
- ☐ Hives ☐ Bruising
- ☐ Hemangioma

Specific infections (plus age or date of infection):

- ☐ Chicken pox_____ ☐ Meningitis_____
- ☐ RSV_____ ☐ Tuberculosis_____
- ☐ Whooping cough (Pertussis)_____

Any other concerns or explanation of above answers?___

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History: Please indicate using the following key any family members who at any time in their lives have been diagnosed with any of these conditions. Please indicate if any family members have died from any of these conditions.

KEY-PLEASE USE THE FOLLOWING IDENTIFIERS FOR FILLING OUT THE FAMILY HISTORY

Mother = Mother of Patient	**Brother** = Brother of Patient	**Grandfather** = Patient's Grandfather	**Aunt** = Mother or Father's Sister	**Cousin** = Cousin of Patient
Father = Father of Patient	**Sister** = Sister of Patient	**Grandmother** = Patient's Grandmother	**Uncle** = Mother or Father's Brother	

Mother's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
Educational difficulties_____
GI disorders (Reflux, Colitis, Crohn's)_____
Hearing loss_____
Heart disease_____
Heart arrhythmia (Prolonged QT, SVT)_____
High blood pressure_____
High cholesterol_____
Hip dysplasia_____
Kidney disease_____
Lazy eye (Strabismus)_____
Melanoma_____
Mental illness_____
Migraine headaches_____
Obesity/Overweight_____
Renal reflux_____
Rheumatological disease_____
Scoliosis_____
Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____

Father's Family History

ADHD_____
Alcoholism/Substance abuse_____
Allergies_____
Alzheimer's_____
Anemia_____
Anxiety_____
Asthma_____
Childhood asthma_____
Arthritis_____
Autism_____
Autoimmune diseases_____
Bipolar disorder_____
Birth defect_____
Bladder problems_____
Bleeding disorders_____
Blood diseases_____
Cancer (Type)_____
Celiac_____
COPD_____
Developmental disabilities_____
Depression_____
Suicide_____
Diabetes_____
Eating disorder_____
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Seizures_____
Epilepsy_____
Stroke_____
Sudden cardiac death_____
Sudden unexplained death_____
Thrombosis (Blood clot)_____
Thyroid disease_____
Other_____