The Pediatric Specialists Medical Group

NEW PATIENT MEDICAL HISTORY-NEWBORN TO 6 MONTHS OF AGE

- THIS FORM MUST BE COMPLETED PRIOR TO YOUR FIRST VISIT.

The following is very important to your child's health. Please complete it accurately and completely.

Child's First Name:_____ Last:_____
Birth Date:_____ Birth Hospital:_____ Birth Weight:_____
Mother's Name:_____ Father's Name:_____
Parent's Marital Status: Single Married Divorced Separated Widowed
Biological Mother: YES NO Biological Father: YES NO
Adoption YES NO Foster Child: YES NO Surrogate/Other_____: YES NO

FAMILY MEDICAL HISTORY	**NO**	**YES**	**If YES-explain**
Nasal Allergies or Other			
Asthma/Lung disease			
Heart Disease or Condition			
High Blood Pressure			
High Cholesterol			
Diabetes			
Cancer-Type?			
Anemia			
Bleeding Disorder			
Epilepsy or Seizures			
Developmental Delay or Intellectual Disability?			
Neurologic Disorders incl. ADD/ADHD			
Liver Disease			
Other GI issues			
Kidney Disease			
Bed Wetting (after age 10)			
Hearing Impairment			
Vision/Eye Disorders			
Immune Problem, Recurrent			
Infections or HIV/AIDS?			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Tuberculosis			

FAMILY SOCIAL HISTORY	**NO**	**YES**	**If YES-explain**
Lives with Intact Family?			
Non-Intact Custody Status?			
Visitation Status of non-custodial parent			
Employed- Mother? FT /PT /Student/____			
Employed Father?-FT /PT /Student/____			
Govn't Assistance-Disability or other?			Type:
Country of birth-Mother			_____ In US for :_____years.
Country of birth-Father			_____ In US for :_____years.
Household- Rent or Own (Circle)			House/ Apt /Mobile Home/or_____
Number of people living in the home			#_____/extended family/other_____
Siblings?			
Pets?			
Smokers in the home			
Firearms in the Home?			
Guns locked & kept apart from ammunition?			
NEWBORN HISTORY-in hospital	**NO**	**YES**	**If YES-explain**
Resuscitation at delivery or baby required assistance with breathing?			
Premature Birth			
Did NOT get Vitamin K and/or eye prophylaxis?			
Feeding Breast or Formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening bloodwork or (to check for infection)?			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first stool?			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopped breathing)			
Needed head ultrasound			
Needed opthamologic (eye) exam			
Other concerns:			

MOTHERS PRENATAL HISTORY	NO	YES	If YES-explain
Was this an assisted conception? (Fertility- help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have an Amniocentesis/CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant? If so what & how often?			
Did you use non-prescription drugs while pregnant? If so what & how often?			
Was there any problem with your baby before birth?			
Did your water break more than 24 hours before delivery?			
Did you have antibiotics or other Medications during labor?			
Was your labor induced (started by medications)?			
Was your delivery Vaginal or by C-section?			
Was there meconium (green bowel movement) present when water broke?			
Other concerns:			