Patient History

Patient Name:_____Date Of Birth:_____

Birth History:

Adopted: Y / N
Multiple Birth: Y / N
Name of Hospital:_____
Term (in weeks):_____
Birth Weight: _____
Birth Length:_____
Condition at Birth (healthy?): Y / N
Please explain if No:_____
Delivery: C-Section / Vaginal
Breast Milk / Formula (type)_____

Assisted Conception: Y / N
Gestational Diabetes: Y / N
High Risk Pregnancy: Y / N
Induction of Labor: Y / N
Maternal Use of Alcohol: Y / N
Maternal Use of Tobacco: Y / N
Maternal Use of Drugs: Y / N
Surgeries (on baby): Y / N
Circumcision (Boys only): Y / N
Jaundice Y / N

Family History

Biological Mother:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Biological Father:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Extended Family History

Please list any family members with these health concerns

Kidney/Liver Disease:_____
Stroke:_____
Cancer:_____
Asthma:_____
Allergies:_____
Sudden Death:_____
Developmental Disability:_____
Seizures:_____

High Cholesterol:_____
High Blood Pressure:_____
Heart Problems:_____
Diabetes:_____
Hypo/Hyper Thyroid:_____
Mental Illness:_____
Reflux:_____
Anemia:_____

Social History

Who lives in home:_____
Smokers in home: Y / N

Pets in Home:_____