SOUTH LAKE PEDIATRICS
HEALTH AND FAMILY HISTORY (BIRTH TO 12 MONTHS)

PATIENT HAME:_______________________________________M______F______DATE:____________

DATE OF BIRTH:____________________COMPLETED BY:______________________________________

Welcome to South Lake Pediatrics. Please complete this form as thoroughly as possible. It will provide us with valuable information about your child and his/her health. This will help us to get to know your child more quickly and allow time for your questions and the information we would like to share with you. Thank you.

Other physicians your child has seen:____

Mother's obstetrician:____

Office location:____City/State:______________________

If referred, reason for referral:____
____
____

PREGNANCY HISTORY	NO	YES	If yes, explain:
Treatment for infertility	____	____	________________________
Medications of any kind	____	____	________________________
Infections / fever	____	____	________________________
X-rays / ultrasound	____	____	________________________
High blood pressure or toxemia	____	____	________________________
Accidents			
Bleeding or spotting	____	____	________________________
Chemical use (alcohol, tobacco, marijuana, cocaine, other.)	____	____	________________________
Gestational Diabetes	____	____	________________________
Preterm labor	____	____	________________________
Hospitalization	____	____	________________________
Any problems, unexpected symptoms, conditions	____	____	________________________
Prenatal chromosome studies	____	____	________________________

BIRTH / NEWBORN HISTORY

Number of living children today:__________

Delivery: (circle)

Full term   Premature

Vaginal   C-section, reason:____________________________

Any maternal complications of labor, delivery or newborn period:______________________
____
____

Is this child adopted: NO YES   Adoption Date:__________

PLEASE COMPLETE BOTH SIDES OF FORM

SOUTH LAKE PEDIATRICS

PATIENT NAME:____

INFANT HISTORY

Birth weight_____________Length:_____________APGARS (if known):_____________

Breast fed *Bottle fed* Name of formula:______________________

Infant condition different than expected? (For example: fever, breathing problems, low glucose, jaundice, physical abnormalities, infection, etc.)

	NO	YES	If yes explain:
In hospital	____	____	________________________
At home	____	____	________________________

GENERAL INFORMATION

	NO	YES
A. Are there any situations which you feel affect you or your family's current stress level? (e.g., change or problem in housing or job; recent health concerns; family issues, etc.)	____	____
B. Do you anticipate help from friends or relatives in the first few weeks at home?	____	____
C. Is / was mother employed?	____	____
Does she plan to return to work?	____	____
If yes, when:__________________________where:_________________________		
D. Are there any particular questions you would like to discuss with us? (e.g. sleep, behavior, circumcision, breast / bottle feeding, sibling rivalry, etc.)	____	____

FAMILY HISTORY

Please check all the conditions, which exist in your child's family or your children. Include (and specify which) grandparents, aunts, uncles, cousins, siblings, parents.

CONDITION:	NO	YES	If yes, explain (who / what):
Allergies (medications, etc.)	____	____	________________________
Asthma	____	____	________________________
Birth defects	____	____	________________________
Bladder / kidney disease or infection	____	____	________________________
Bowel (ulcer, colitis, etc.)	____	____	________________________
Cancer	____	____	________________________
Chemical problems (alcohol, tobacco, marijuana, cocaine, other)	____	____	________________________
Diabetes Mellitus	____	____	________________________
Ear problems / infections	____	____	________________________
Eczema / psoriasis	____	____	________________________
Emotional problems (nervous break-down, suicide, other)	____	____	________________________
Hearing problems (hearing aid, etc.)	____	____	________________________
Heart problems (heart attack, murmur, etc.)	____	____	________________________
High blood pressure / stroke	____	____	________________________
High cholesterol	____	____	________________________

PLEASE COMPLETE BOTH SIDES OF FORM **OVER →**

SOUTH LAKE PEDIATRICS

PATIENT NAME:____

FAMILY HISTORY (continued)

CONDITION:	NO	YES	If yes, explain:
Infant or childhood deaths	____	____	______________________
Learning problems (mental retardation, dyslexia, other)	____	____	______________________
Lung problems (emphysema, tuberculosis, cystic fibrosis, etc.)	____	____	______________________
Obesity	____	____	______________________
Seizure disorder (epilepsy, etc.)	____	____	______________________
Sickle cell	____	____	______________________
Thyroid problems	____	____	______________________
Vision problems (blindness, lazy eye, cataract, etc.)	____	____	______________________
Any chronic condition or unusual diseases not mentioned	____	____	______________________

Mother's general health:______________________________________

Father's general health:______________________________________

Date	Physician review	Date	Physician review	Date	Physician review

Revised 11/05