Auburn Pediatrics

Patient Name_____**DOB**_____ **Sex M / F Date**_____

Parent/Sibling Information

Name	Age	Sex	Relationship	Health Status

Family History (Please circle all that apply)

Anemia Asthma
Bleeding Disorder Allergies
Blood Transfusion Hypertension
Substance Abuse Heart Attack≤50
Thyroid Problem Seizures
High Cholesterol Cancer
Alcohol Abuse Diabetes
Epilepsy If yes, please explain___
_____
_____

Parents marital status M D S other_____ Child is living with_____

Pregnancy History

Prenatal Care Y/N where?_____
During pregnancy did you? (circle all that apply)
Smoke take medication
Use alcohol use drugs

Birth History

Baby's APGAR scores:_____
Birth Weight_____ Length_____
Head Circumference_____
Delivery vaginal / c-section

Nutritional History

Breast Fed Y / N How often?_____
Formula Fed Y / N How often?_____
Vitamins/Fluoride Y / N Suplements_____
Water Supply city / well _____

Development History

At what age did your child:
roll over_____ walk_____
sit up_____ talk_____
stand_____

Any Concerns?_____

Past Medical History

Has your child ever had any of the following? (Circle all that apply)

Chickenpox Asthma Surgery/Hospitalization (please explain)_____
Measles Allergies _____
Ear Infections Pertussis Other: _____
Seizures Pneumonia _____

Child's Interests and Hobbies:

Pets_____ Favorite TV Show_____
Sports_____ Favorite Books _____
Other Interests _____