New Patient Information

Pregnancy and Birth

Mother's age at birth of child:_____

Did mother have any illness during the pregnancy? Yes No

Did mother take any medications other than vitamins? Yes No

In what hospital was the child born:_____

Was baby full term? Yes No

Was baby born C-section or vaginal:_____

Obstetrician's name:_____

Birth weight:_____ Length:_____

Did baby have any trouble starting to breathe? Yes No

Did baby have any trouble while in hospital? Yes No

If yes please explain:_____

_____

Did baby receive Hepatitis shot in the nursery? Yes No

Any other important information we may need to know about birth:

_____

_____

Family History

Are child's parents both in good health? Yes No

Circle any diseases or conditions that are in either parent"s family history:

alcohol problems	allergies	asthma	blood disorders
cancer	diabetes	drug problems	epilepsy
heart problems	high blood pressure	high cholesterol	kidney disease
liver disease	lung disease	lupus	multiple sclerosis
muscular dystrophy	SIDS	mental illness	tuberculosis

Other:_____

Does the child have siblings? Yes No

If so please list: Name Age Sex

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

Have any siblings died? Yes No

Any other family information:_____

_____

_____