PATIENT INFORMATION

Patient Name:	M/F	DOB:

Obstetrician: _____ Birth Hospital: _____

Illness During Pregnancy: _____

Medications during pregnancy: _____ Full Term/ Premature

Type of Delivery: Vaginal/ C-section _____ Apgar Score: _____

Complications of Birth Process: _____

Problems after birth: Respiration/ Jaundice _____

Birthweight: _____ Length: _____ Feeding: Breast/ Formula _____

Current Medical Problems: _____

Allergies to Medications: _____ Current Medications _____

Hospitalizations: (when, where, why?) _____

Surgeries: (when, where, why?) _____

Immunizations: Up to date (Y/N) _____

School: (grades/ any problems?) _____

FAMILY HISTORY

	Age	Health	Occupation	Any Family History of:
Father				__High Cholesterol
Mother				__cancer __asthma
Sibling (M/F)				__seizures__TB
Sibling (M/F)				__heart disease
Sibling (M/F)				__deafness__diabetes
Sibling (M/F)				__mental retardation

_____

Physician Signature Date