

Pediatric Associates Patient Registration

Patient Name: _____ Date of Birth: _____

Patient's Doctor: _____

Date: _____

Birth History:

Birth Hospital: _____ OB Doctor: _____

Birth weight: _____ Length: _____ Head circumference: _____ Apgar scores: _____

Preterm (<36 weeks): _____ Term (37-41 weeks): _____ Post-term (>41 weeks): _____

Mother's total number of pregnancies: _____ Number of this child: _____ Number of Miscarriages: _____

Medications taken during pregnancy: _____

Hepatitis B vaccine given at hospital: Y N Newborn Hearing screen passed: Y N

Please circle any that apply to your pregnancy:

Diabetes High blood pressure Mother smoked (How much? _____)

Forceps used Infection Mother used drugs (Which? _____)

Anemia Planned pregnancy Mother drank alcohol (How much? _____)

Child's Medical History:

Please list any chronic or recurring medical problems:

Current Medications along with doses: _____

Allergic reaction to any medications or latex: _____

Hospitalizations: _____

Surgeries: _____

Social History:

Who has legal custody of this child? _____

If parents are separated/divorced and have split custody, please explain the living arrangement and occupants of both homes:

Education: Public school: _____ Private school: _____ Home Schooled: _____ Special needs: _____ IEP: _____