PATIENT INFORMATION SHEET

PATIENT INFORMATION

Patient Name:____
DOB: _____ / _____ / ____ Age: __________Sex: ___________
Total number of living children _____ Mother's age at birth ____
Number of years between previous pregnancy & this child _____
Prenatal Care Provider ___________________________________
Trimester Prenatal Care Began: **1 2 3** Vitamins: **Y N** Iron: **Y N**
____Term ____Premature (__Weeks) ____Overdue (__Weeks)
____Vaginal ____C-Section ____Forceps
____Breech ____Multiple birth ____Other

MATERNAL COMPLICATIONS

____Vaginal bleeding ____Anemia
____Hyper tension ____Rh negative
____Diabetes ____Premature labor
____Injury/hospitalization/surgery ____Flu-like illness or high temp.
____Kidney or bladder infection ____STDs
____Hepatitis (A, B, or C) ____Exposure to TB
____Exposure to lead/chemicals ____Dental disease

NURSERY COURSE

Birth Weight _______ Birth Length ________
____Difficulty with initial breathing
____Hear t murmur
____Infection
Newborn blood screening (date/location):
1. _______________________ 2. ________________________
Newborn hearing test (in hospital): **Normal** **Abnormal**

FEEDING & NUTRITION

Food Allergies ____
Appetite usually good? ***Yes No***
Colic or feeding problems during the first 3 months? ***Yes No***
Breast fed? ***Yes No*** Number of months ___________
Formula? ***Yes No*** Current Brand _______________
Vitamins? ***Yes No*** Brand______________________
Special Diet?____

ALLERGIC REACTIONS

Medicine ____________________ Food ______________________
Animals _____________________ Insect _____________________
Immunizations up to date? ***Yes No***
Do you have the immunization record with you today? ***Yes No***
Medications taken on a regular basis? (exclude vitamins)
____

CHILD'S MEDICAL HISTORY

Immunizations current: **Y N** Dental care/sealants current: **Y N**
____Trauma/injuries ____Hospitalizations
____Surgery ____Medications
____Anemia ____Early childhood caries
____Hepatitis ____Strep throat
____Ear infections ____Bladder/kidney infections
____Pneumonia ____Developmental delays
____Vision problems ____Hearing problems
____Seizures ____Allergies
____Asthma ____Eczema
____Environmental toxin exposure (lead, etc.) ____Substance use (alcohol, drug, tobacco)
Other ____

FAMILY PROFILE

PARENTS ▫ Married ▫ Separated ▫ Divorced

RELATION	NAME	DOB	HEALTH
Mother	____________________	____________	_______________
Father	____________________	____________	_______________
Sibling	____________________	____________	_______________
Sibling	____________________	____________	_______________
Sibling	____________________	____________	_______________

Pets? ______________________ Smokers?___________________

FAMILY MEDICAL HISTORY

M – Mother F – Father S - Sibling
PGM - Paternal Grandmother PGF - Paternal Grandfather
PA - Paternal Aunt PU - Paternal Uncle
MGM - Maternal Grandmother MGF - Maternal Grandfather
MA - Maternal Aunt MU - Maternal Uncle

____ Anemia//blood disorder ____ Heart disease before age 50
____ Cholesterol req. treatment ____ Hyper tension/stroke
____ Asthma/allergy ____ Cancer
____ Diabetes ____Epilepsy/seizures
____ Kidney problems ____ Muscle/bone disease
____ Genetic disea / maj birth defects ____ Childhood hearing impairment
____ Tuberculosis **Y N** HIV + individual in household
____ Other immunosuppression ____ Dental decay
____ Alcohol/drug abuse ____ Tobacco use
____ Learning disorder ____ Mental retardation
____ Psychiatric disorder ____ Phy/sexual/emotionl abuse
____ Domestic violence ____ Other

DEVELOPMENT & BEHAVIOR

AT WHAT AGE CHILD
Sat alone ______ Walked ______ Used sentences ______
Toilet trained ______ Bicycled ______
Grade in school ______ Getting along with other children ***Yes No***
Development compared to other children? ______________________
Problems in school (learning/behavior)___________________________
____
Bad habits ____
Bedwetting? ***Yes No*** Nail biting? ***Yes No***
Sleeping? ***Yes No*** Use of street or illegal drugs? ***Yes No***
Hobbies____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Huebner Pediatrics for services rendered by Dr. Gonzalez in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

SIGNATURE___________________________ DATE _________