WELCOME TO ST. JOSEPH PEDIATRICS!!
In order for us to provide your child with the best possible care, please fill out the following form to the best of your ability.
Thank you!

6 months-Toddler

Child's Name:_______________________ **Date of Birth:**_________ **Age:**_________

Ethnicity: __________________________ **Language:** _________________________

Child's Previous Doctor:____

Who referred you to us?____

Present Health Concerns:____

Past Medical History:____

Hospitalizations---Where? When? Why? ___________________________

Surgeries---Where? When? Why? _________________________________

Medications/Herbs/Vitamins:

Name	Amount	How Often?

Allergies:

Name of Medication	Type of Reaction

Pregnancy and Birth

Where was your child born? ____

Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Foster Care ☐Other

Please indicate any medical problems during pregnancy:___________________

Delivery by: ☐Vaginal Birth ☐Caesarean Section—why? ___________

Birth Weight ___________ If premature, how early? ________________

Please indicate any medical problems during the newborn period:___________

Nutrition and Feeding

Was your child breastfed? □No □Yes If yes, how long? _______________

Current formula: ______________________

Has your child had any unusual feeding/dietary problems?

____

Any current nutritional deficits? ______________________________________

Sleep

Hours per night _____________ Naps (number & length) ____________

Any sleep problems?____

Development

At what age did your child: Sit alone _______ Walk alone _________

Say words ______ Toilet train _________

Are there any functional deficits? _______________________________

Dental history

Has child been seen by a dentist? □No □Yes—How Often? ________ Last visit _______

Exposures/Habits

Any concerns about lead exposure? (old home/plumbing/peeling paint) □No □Yes

Do any household members or caregivers smoke? _____________________________

TV/computer/video games----hours per day ____________

Social History

Who lives at home?

Name	Age	Relationship

Pets: ____

Are your child's parents □Married □Unmarried □Separated □Divorced

Does your child attend daycare? □No □Yes

Do you have concerns about your child's behavior: If so, what? ______________

Does your child live in a safe environment? □No □Yes

Family History

Please indicate if any family members have had any of the following conditions and, if so, whom?

ADHD	Anemia	Asthma
Autoimmune disorder	Birth defect	Bleeding problem
Cancer (under age 50)	Diabetes I or II	Eczema
Food Allergy	Genetic Disorder	High Cholesterol
High blood pressure	Mental Retardation	Kidney Disease

Heart attack/heart disease (under age 50)		SIDS

THANK YOU!