



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!

Child's Name: _____ **Date of Birth:** _____ **Child 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:

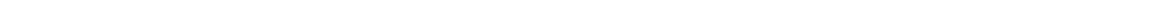
Name of Medication	Type of Reaction
_____	_____
_____	_____

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

Has your child had any unusual feeding/dietary problems?

Any current nutritional deficits? _____

Sleep

Hours per night _____

Any sleep problems? _____

Development

Girls only: Age at first menstrual period _____

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? _____

Alcohol use

Tobacco use

Sexual activity

Does your child live in a safe environment? No Yes



School History

Current grade _____ Name of School _____

Any concerns about school performance? _____

Sports? _____

Other extracurricular activities? _____

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!
