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

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
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!