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!

0-6 Months

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? _________________________________

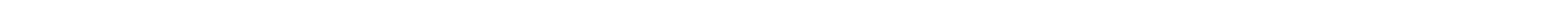
Medications/Herbs/Vitamins:
Name Amount How Often?
____
____

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

Has your child been 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?____

Exposures/Habits

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

Do any household members or caregivers smoke? _____________________________

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	