Eastside Pediatric Group

1. IDENTIFICATION (PLEASE PRINT)

DATE **CHART NO.**

Child's Name _____
Last First Nickname

Birthdate _____ Male_____ Female _____

Child lives with:_____ Tel. No._____
(parents, mother, father, etc)

Address _____

Child's School _____

Address _____

Delivery Hospital _____

Address _____

Mother's Name _____

Circle One: Single Separated Married Divorced Widowed

Address Bill To: _____

Address_____

Employer _____

Address _____

Health Insurance_____ Policy No. _____

Medicaid Number (if any)_____

2. CHILD'S BIRTH HISTORY

During your pregnancy with this child, did you:

Have high blood pressure?…….. .YES ( ) NO ( )
Have diabetes or sugar in your urine?…….YES ( ) NO ( )
Have albumin or protein in your urine?.....YES ( ) NO ( )
Have a urinary infection?.....YES ( ) NO ( )
Have Rubella or German measles?.....YES ( ) NO ( )
Take medicines prescribed by your doctor?...YES ( ) NO ( )
Frequently smoke cigarettes?……YES ( ) NO ( )
If YES, about how many packs a day…….._____per day
Have a venereal disease such as gonorrhea , HIV Or syphilis……..YES ( ) NO ( )
Have a dependence on drugs or alcoholic beverages YES ( ) NO ( )
If YES, please explain:_____
Other Conditions:_____

How long was your pregnancy? _____
How early did you start seeing a doctor?....._____MTHS
Was this child premature?……..YES ( ) NO ( )
Was more than one baby born?.....YES ( ) NO ( )
Did you have a difficult delivery?.....YES ( ) NO ( )
If YES: Was it a breech (bottom first) delivery…YES ( ) NO ( )
Or, was it a cesarean delivery……..YES ( ) NO ( )
What was your child's weight at birth?.....
Was there an Rh problem?.....YES ( ) NO ( )
Was anything wrong with your child at birth?..... .YES ( ) NO ( )
If YES, what? _____

3. MATERNAL AND FAMILY HISTORY

How many children have you (mother) had……_____
Which one is this child?.....
Have you (mother) had any premature births?.....YES ( ) NO ( )
Have your (mother) had any cesarean births……..YES ( ) NO ( )
Have you (mother) had any miscarriages?.....YES ( ) NO ( )
Mother's age now _____ Mother's height_____
Father's age now _____Father's height _____
Number of people living in child's home……_____
Who spends most time caring for child? (father, mother, etc)
_____

4. FAMILY ILLNESSES

Please mark an "X" in the boxes where your child's blood relatives have ever had any of the following illnesses. Some examples of illnesses are shown in the parentheses ( ).

	Father	Mother	Father's Side	Mother's Side	Sisters	Brothers
Allergies (medicines, foods pollen)……						
Birth defects……						
Blood Disease (hemophilia, anemia, leukemia)….						
Bone or joint disorders……						
Cancers or malignancies……						
Chronic lung disease (asthma, chronic bronchitis)						
Eye or ear disorders……						
Glandular disease (diabetes, thyroid desease)…						
Heart trouble……...						
Kidney or urinary disease……						
Mental retardation……						
Muscle disease (weakness, poor control)…….						
Nerve disease (cerebral palsy, epilepsy)……..						
Psychiatric condition……						
Rheumatic fever……						
Tuberculosis (T.B.)……						
Venereal disease (syphilis, gonorrhea, HIV)						
Other_____						

If your CHILD has ever been hospitalized for any serious . Medical illness or operation, enter the most recent occurrences below. Check this box if there were more then two hospitalizations ☐

	HOSPITALIZATION (1)	HOSPITALIZATION (2)
Illness or Operation		
Year Hospitalized		
Name of Hospital		
City and State		