NEW PATIENT REGISTRATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

PRENATAL HISTORY

Total # Pregnancies_____ # Live Births____ # Living Children____ # Still Births____ # Miscarriages____

Were you sick during this pregnancy? Yes ☐ No ☐

What hospital was the baby born at? _____

During this pregnancy did you have:

Baby's birth weight _____

German Measles Yes ☐ No ☐

Unexplained rash Yes ☐ No ☐

Anemia Yes ☐ No ☐

Sexually Transm'd Disease Yes ☐ No ☐

Protein in urine test Yes ☐ No ☐

Kidney Infections Yes ☐ No ☐

Injuries/Accident Yes ☐ No ☐

Bleeding/Spotting Yes ☐ No ☐

Excessive weight gain Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

Diabetes Yes ☐ No ☐

RH problem Yes ☐ No ☐

X-Ray Yes ☐ No ☐

Did you smoke/drink alcohol/or use drugs Yes ☐ No ☐

Take vitamins and/or iron Yes ☐ No ☐

Was child born ☐ early ☐ on time ☐ overdue

Length of labor ☐ under 2 hours ☐ over 12 hours

Difficulty at delivery Yes ☐ No ☐

Breech ☐ Cesarean ☐

Other problems _____

Anesthesia Yes ☐ No ☐

Awake at birth Yes ☐ No ☐

Did baby fail to cry immediately Yes ☐ No ☐

Was baby in special nursery Yes ☐ No ☐

Was baby in hospital longer than mom Yes ☐ No ☐

Other _____

When did you seek prenatal care ☐ 1st trimester

☐ 2nd trimester ☐ 3rd trimester ☐ not at all

During this pregnancy were you ever hospitalized?

Yes ☐ No ☐

If yes, reason _____

Other medications (Please List):

_____

_____

_____

Other

_____

-See over-

FAMILY HISTORY: INDICATE IF ANY OF THE FOLLOWING ARE IN THE FAMILY. CHILD'S GRANDPARENTS, AUNTS, UNCLES, BROTHERS OR SISTERS

	DISEASE PROBLEM	RELATIONSHIP		DISEASE PROBLEM	RELATIONSHIP
YES ☐ NO ☐	HYPERTENSION		YES ☐ NO ☐	ASTHMA/HAY FEVER,ECZEMA	
YES ☐ NO ☐	HEART DISEASE		YES ☐ NO ☐	MENTAL ILLNESS	
YES ☐ NO ☐	KIDNEY TROUBLE		YES ☐ NO ☐	BIRTH DEFECTS	
YES ☐ NO ☐	TUBERCULOSIS		YES ☐ NO ☐	MENTAL RETARDATION	
YES ☐ NO ☐	DIABETES		YES ☐ NO ☐	SCHOOL PROBLEMS	
YES ☐ NO ☐	CANCER/TUMORS		YES ☐ NO ☐	POOR VISION, HEARING, SPEECH	
YES ☐ NO ☐	CONVULSIONS/EPILEPSY		YES ☐ NO ☐	ALCOHOL DEPENDENCY	
YES ☐ NO ☐	BLEEDING PROBLEMS		YES ☐ NO ☐	DRUG DEPENDENCY	
YES ☐ NO ☐	ANEMA/SICKLE CELL		YES ☐ NO ☐	OTHER INHERITED DISEASE	

SOCIAL HISTORY FAMILY CONSTELLATION

YEARS AT PRESENT ADDRESS _____ SINGLE PARENT VS TWO PARENTS _____

LIVING WITH SOMEONE OTHER THAN NATURAL PARENT_____

FAMILY CONSTELLATION

NAME	RELATIONSHIP AGE	OCCUPATION	PLACE OF EMPLOYMENT	LIVING IN HOME YES/NO
	MOTHER			YES ☐ NO ☐
	FATHER			YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

PRIMARY LANGUAGE OF FAMILY _____ RACE _____ ETHNICITY _____

WOULD YOU LIKE TO TALK TO ONE OF THE PHYSICIANS ABOUT: ☐ OTHER FAMILY NEEDS FOR HEALTH CARE

☐ BIRTH CONTROL ☐ FAMILY FINANCE ☐ HOUSING ☐ FAMILY PROBLEMS ☐ MARTIAL PROBLEMS

☐ DAY CARE ☐ SCHOOL OTHER _____