BIRTH TO 5 YEARS

Date:________________PATIENT:___________________________________D.O.B_______________

Are you interested in receiving your lab and test results electronically in the future? **YES** **NO**

Email address: ____

Patient's Past Medical History

Prior Testing/ Developmental Test	None	Yes	Test:___________________
Allergies	No	Yes	Date_______________
History of Chicken Pox	No	Yes	
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Ear Disorder	No	Yes	
Eye Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth. Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU / Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric / Learning Disorder	No	Yes	
Respiratory Disease / Asthma	No	Yes	
Skin Disease	No	Yes	
History of injury / trauma	No	Yes	

Other Chronic Problems: ____

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Family Medical History **List family member and details**

Bleeding Disorder	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Congenital Heart Disease	No	Yes	
Heart Disease before 50	No	Yes	
Eye Disorder	No	Yes	
Ear Disorder	No	Yes	
Respiratory Disorder	No	Yes	
GI Disorder	No	Yes	
GU Disorder	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric Disorder	No	Yes	
SIDS	No	Yes	
Skin Disease	No	Yes	
Other			

Birth History

Birth Weight		____
Discharge Weight		____
Length		____
Head Circumference		____
Gestational Age	Full Term	Weeks:__________________________________
Birth Location/ Hospital		____
Type of Delivery/ Complications	None	____
Birth Complications	None	____
Apgar Scores		____
Oxygen at Birth		Yes No
NICU Stay		Yes No How Long?_________________
Synagis Prophylaxis given at hospital		Yes No
Hep B given at birth		Yes No
Mother's pregnancy health		Normal? _________________________________

Newborn Screening Test

Newborn Hearing Test	NL	ABN	Not Performed
Newborn State Screen	NL	ABN	Not Performed
Other Newborn Screening Test	NL	ABN	Not Performed

Surgical/Hospitalization History

			Details
Non surgical hospitalizations	None	Yes	
Surgical history	None	Yes	
Ear surgery	None	Yes	
Eye surgery	None	Yes	
Nose/mouth/throat surgery	None	Yes	
Cardiovascular surgery	None	Yes	
GI surgery	None	Yes	
GU Surgery	None	Yes	
Eye surgery	None	Yes	
Orthopedic surgery	None	Yes	
Other surgery	None	Yes	

Child Social History

Patient information: (circle all that apply)

Parents together	Father Involved	Father Not Involved	Mother/Father Deceased
Lives with Mother	Mother Involved	Mother Not Involved	
Lives with Father	Guardian Parents	Same sex Parents	

Child care: Name of daycare: ____

Home occupants (list all) ____

Parent's smokers: (circle one) NO YES Outside only

Pets: What kind, how many, inside or outside?____

Extracurricular activities: (sports, music, etc.)____