

**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

Was child born  early  on time  overdue

Unexplained rash Yes  No

Length of labor  under 2 hours  over 12 hours

Anemia Yes  No

Difficulty at delivery Yes  No

Sexually Transm'd Disease Yes  No

Breech  Cesarean

Protein in urine test Yes  No

Other problems \_\_\_\_\_

Kidney Infections Yes  No

Anesthesia Yes  No

Injuries/Accident Yes  No

Awake at birth Yes  No

Bleeding/Spotting Yes  No

Did baby fail to cry immediately Yes  No

Excessive weight gain Yes  No

Was baby in special nursery Yes  No

High blood pressure Yes  No

Was baby in hospital longer than mom Yes  No

Diabetes Yes  No

Other \_\_\_\_\_

RH problem Yes  No

When did you seek prenatal care  1<sup>st</sup> trimester

X-Ray Yes  No

2<sup>nd</sup> trimester  3<sup>rd</sup> trimester  not at all

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

During this pregnancy were you ever hospitalized? Yes  No

Take vitamins and/or iron Yes  No

If yes, reason \_\_\_\_\_

Other medications (Please List): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

-See over-

Other \_\_\_\_\_

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

DISEASE PROBLEM		RELATIONSHIP	DISEASE PROBLEM		RELATIONSHIP		
YES <input type="checkbox"/>	NO <input type="checkbox"/>	HYPERTENSION		YES <input type="checkbox"/>	NO <input type="checkbox"/>	ASTHMA/HAY FEVER, ECZEMA	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEART DISEASE		YES <input type="checkbox"/>	NO <input type="checkbox"/>	MENTAL ILLNESS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	KIDNEY TROUBLE		YES <input type="checkbox"/>	NO <input type="checkbox"/>	BIRTH DEFECTS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	TUBERCULOSIS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	MENTAL RETARDATION	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	DIABETES		YES <input type="checkbox"/>	NO <input type="checkbox"/>	SCHOOL PROBLEMS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	CANCER/TUMORS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	POOR VISION, HEARING, SPEECH	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	CONVULSIONS/EPILEPSY		YES <input type="checkbox"/>	NO <input type="checkbox"/>	ALCOHOL DEPENDENCY	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	BLEEDING PROBLEMS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	DRUG DEPENDENCY	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	ANEMIA/SICKLE CELL		YES <input type="checkbox"/>	NO <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/>
	FATHER				YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>

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  MARITAL PROBLEMS

DAY CARE  SCHOOL OTHER \_\_\_\_\_