Northpointe Pediatrics, P.C.

(Under 3)

Last Name_____First Name_____Nickname_____D.O.B_____

QUESTIONS PERTAINING TO MOTHER'S PREGNANCY:

How many times has mom been pregnant? ____How many children does she have? ____ How long was this pregnancy? _____

While pregnant were alcohol, drugs or cigarettes used? ☐No ☐Yes, how much?_____

Any infections during pregnancy (including Group B Strep)? ☐No ☐Yes, explain _____

Any complications with pregnancy? ☐No ☐Yes, explain _____

QUESTIONS PERTAINING TO MOTHER'S DELIVERY:

Type of delivery: ☐Vaginal ☐C-section Was the delivery induced? ☐No ☐Yes, explain_____

Was the delivery: ☐Routine ☐Emergent Any complications with or after delivery? ☐No ☐Yes, explain _____

Birth Weight _____ Birth Length _____ Mother's Blood Type _____ Child's Blood Type _____

Hearing Screen : ☐PASS ☐FAIL Type of feeding: ☐Breast ☐Formula Formula Name_____

Hepatitis B at Birth? ☐Yes ☐No Date: _____/_____/_____ Discharge Date _____/_____/_____ Weight_____

Birth Hospital _____Obstetrician_____Pediatrician(in hospital)_____

MINOR/CHILD'S HEALTH HISTORY:

Minor/Child's Previous Physician_____

City/ State _____ Phone ( ) _____ - _____

HAS MINOR/CHILD HAD ANY HISTORY OF/OR DIFFICULTY WITH ANY OF THE FOLLOWING:

☐ Acne	☐ Constipation	☐ Heart Disease	☐ Strep throat, recurrent
☐ ADD/ADHD	☐ Developmental delay	☐ High Blood Pressure	☐ Stroke
☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Disease
☐ Allergies	☐ Diarrhea	☐ Mental Illness	☐ Tonsillitis
☐ Anemia	☐ Drug abuse	☐ Mononucleosis	☐ Tuberculosis
☐ Asthma	☐ Ear Infections, recurrent	☐ Obesity	☐ Urinary Tract Infections
☐ Bed Wetting	☐ Eczema	☐ Pneumonia	☐ Vision Problems
☐ Birth Defects	☐ Epilepsy	☐ Prematurity	☐ Other _____
☐ Bleeding	☐ Fainting	☐ Seizures	_____
☐ Cancer	☐ GERD (Reflux)	☐ Sinus Problems	_____
☐ Chicken Pox	☐ Hearing Problems	☐ Speech delay	_____

Medications Minor/Child is on:_____

Allergies of Minor/Child: _____

Hospitalizations and/or Surgeries:

Date _____ Reason(s)_____ Hospital _____

Date _____ Reason(s)_____ Hospital _____

Date _____ Reason(s)_____ Hospital _____

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FAMILY HISTORY (HAS ANY MEMBER OF THE FAMILY OR CLOSE RELATIVE HAD ANY OF THE FOLLOWING):

☐ ADD/ADHD	Who? _____	☐ High Blood Pressure	Who? _____
☐ Alcoholism	Who? _____	☐ High Cholesterol	Who? _____
☐ Allergies	Who? _____	☐ Mental Illness	Who? _____
☐ Asthma	Who? _____	☐ Obesity	Who? _____
☐ Bed-wetting	Who? _____	☐ Seizures	Who? _____
☐ Cancer	Who? _____	☐ Stroke	Who? _____
☐ Diabetes	Who? _____	☐ Sudden or unexpected death	Who? _____
☐ Drug Abuse	Who? _____	☐ Tuberculosis	Who? _____
☐ Eczema	Who? _____	☐ Urinary Tract/Bladder Infections	Who? _____
☐ GERD (Reflux)	Who? _____	☐ Other_____	Who? _____
☐ Heart Disease	Who? _____		

SOCIAL HISTORY:

Who is living in your home?

What is your child's sleep position? ☐Back ☐Stomach ☐Side

Does your child use a ☐car seat ☐seat belt?

Is your child in daycare? ☐No ☐Yes

Are there any smokers in the house? ☐No ☐Yes If so, do they smoke ☐Inside ☐Outside?

Are there any firearms in the house? ☐No ☐Yes If so, are the locked up? ☐No ☐Yes

Was your house bulit before 1978? ☐No ☐Yes Is there any peeling paint in the house? ☐No ☐Yes

Do you have smoke detectors and a fire escape plan?: ☐No ☐Yes