BIRTH TO 5 YEARS

Date:_____ **NAME:** _____ **DOB:**_____

Pharmacy:_____

Please Circle One:

Primary Language in home: English Spanish Other

Ethnicity: Not hispanic or Latino Hispanic or Latino

Race: White Asian Native Hawaiian/Pacific Islander Black/African American 2 or more races Prefer not to answer

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	
History of Chicken Pox	No	Yes	Date:
Cancer	No	Yes	
Blood/Lymph 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	Details:
Other Chronic problems			

Family Medical History

Please List Family Member and details below

Cancer		No	Yes
Diabetes		No	Yes
Heart disease		No	Yes
Eye disorder		No	Yes
Ear disorder		No	Yes
Respiratory disorder		No	Yes
GI disorder		No	Yes
GU disorder		No	Yes
Musculoskeletal disorders		No	Yes
Neurologic disorder		No	Yes
Psychiatric disorder		No	Yes
Sudden Infant Death		No	Yes
Skin disease		No	Yes
Other			

Birth History

Birth Location/Hospital			
Birth weight			
Discharge weight			
Length			
Head circumference			
Gestational age	Full Term		Weeks:
Type of delivery/complications	None		
Birth complications	None		
Apgar Scores			
Oxygen at birth	Yes	No	
NICU Stay	Yes	No	How Long:
Synagis prophylaxis given in 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	
Cardiovasular Surgery		None	Yes	
GI Surgery		None	Yes	
GU Surgery		None	Yes	
Eye Surgery		None	Yes	
Orthopedic Sugery		None	Yes	
Other Surgery		None	Yes	

Child Social History

Parent information: *(circle all that apply)*

Parents together	Father involved
Lives w/mother	Mother involved
Lives w/father	Father not involved
Guardian parents	Mother not involved
Same sex partners	Mother / Father deceased

Child care: Name of Daycare: _____

Home occupants (list all): _____

Parents smokers: (Circle one)

No Yes Outside only Yes

Pets, what kind, how many, inside or outside? _____

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