LANCASTER PEDIATRIC ASSOCIATES, LTD.

Birth History

Patient's First/Last Name: ____ Birthdate: ___________________

Age ___________ Date ____________________

Please list the following: (Nurses, please enter under the "Basic Information" tab)

Primary Language:

Race: Declined to specify (circle)

Ethnicity: Declined to specify (circle**)**

Birth Weight: _________________ Birth Length: _________________

Delivering Hospital: ____

Was the baby born at term? Yes or No

If early, how many weeks? _________ If late, how many weeks? _________

Type of delivery? Vaginal or Cesarean

If Cesarean, why? ____

Any problems with the baby's health after birth? Yes or No

If yes, please explain:

____

Type of feeding your baby has been getting? Breast Formula Both

Illnesses or problems with the mother's health during pregnancy? Yes or No

If yes, please explain:

____

____

During the pregnancy, did Mother use tobacco products? Yes or No Consume alcohol? Yes or No

If yes, please explain:

____

Please list any maternal medications taken during pregnancy:

____

____

Past Medical History

Patient's First/Last Name: ____ Birthdate ______________________

This form is necessary to provide the "complete picture" of your child's health to your provider. By gathering this information, it allows your provider to offer the best care possible for your child(ren).

Patient's Past Medical History—Please Print

1. Please list any previous hospitalizations? (list month/year, hospital and reason for hospitalization)
   ☐None

   ___
2. Please list any previous surgeries? (list month/year, hospital and surgery performed) ☐None

   ___
3. Please list any serious injuries or accidents? (list month/year and nature of injury/accident) ☐None

   ___
4. Any drug or food allergies? ☐Yes ☐No (if yes list below with reaction)

   ___
5. Does your child have any special communication needs? ☐Yes ☐No (If yes, please explain below)

   ____
6. Does your child see a dentist? ☐Yes ☐No If yes, who: __________________________
   Date of last visit: ________________

Please **CIRCLE** any condition your child currently has or has had in the past:

Chicken pox

If Yes When? _______________

Eye conditions/corrective lenses

Frequent ear or sinus infections

Problems with ears or hearing

Frequent pharyngitis or tonsillitis

Allergic rhinitis or other allergy

Indoor allergens:__________________

Outdoor allergens:________________

Asthma

Frequent bronchitis, bronchiolitis, or pneumonia

Recurrent Croup

Other chronic/serious lung disease

Tuberculosis or positive TB test

Congenital/acquired heart defect

Constipation requiring visits

Please explain any conditions you circled above or explain any other medical conditions:

____

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Bladder, kidney infection or other urologic problems

Thyroid or other endocrine problem

Diabetes

Chronic or recurrent skin problem (acne, eczema, etc.)

Frequent headaches

Seizures or other neurologic problems

Developmental delay or disorder

Behavior disorder (ADHD, ODD, other)

Cancer

HIV/AIDS

Orthopedic problem

High Cholesterol

High blood pressure

Heart murmur

Anemia or bleeding problem

Blood transfusion

Frequent abdominal pain or GERD

Family History

Patient's First/Last Name: ____ Birthdate ______________________

Family History—Check all that apply. ONLY include GENETIC family members.

(Leave blank if the child is a foster child, adopted, or if the biological parents are unknown.)

	Mom	Dad	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer								
Asthma/Other Lung Disease								
Nasal/Other Allergies								
Diabetes or Other Endocrine Problems (before 50 years old)								
High Blood Pressure								
High Cholesterol								
Heart Disease (before 50 years old)								
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)								
Kidney Disease								
Liver Disease								
Anemia								
Bleeding Disorder								
Developmental Delay/Disorder								
Mental Illness								
Epilepsy, Convulsions, or Seizures								
Neurologic Disorder								
ADHA/ADD								
Autism								
Alcohol Abuse								
Drug Abuse								
Hearing Problems/Deafness								
Vision Impairment/Eye Disorder (not including standard glasses or contacts)								
Tuberculosis								
Bed-wetting (after 10 years old)								
Immune Problems, Recurrent Infections, or HIV/AIDS								
Milk and/or Soy Intolerance								
Other GI Disease/Disorder								
Unexplained Sudden Death (before 50 years old)								

Additional Pertinent Conditions

Explain ____

If no significant family history, please check here: ☐

Social History

Patient's First/Last Name: ____ Birthdate ____________________

Social History—Please Print

List the name of those LIVING IN THE HOUSEHOLD- include any parents, siblings, any extended family, step-family, grandparents, others	**Date of Birth**	**Relationship to Child**

1. Parents' Marital Status: □Married □Divorced □Separated □Never Married □Other

____

2. If parents are not living together or if the child does not live with parents, what is the child's custody status? ____

3. What is the visitation status of any non-custodial parent(s)? ____

____

4. Daytime Status: □Home □Daycare □School

5. Does anyone in the household smoke? □Yes □No

6. Does anyone at daycare smoke? □Yes □No □Not applicable

7. Are there pets in the home? □Yes □No

If yes, what type of pets? ____

8. Are there pets in the daycare? □Yes □No □Not applicable

If yes, what type of pets? ____

9. Are there firearms in the home? □Yes □No

10. Are the guns locked and kept separate from ammunition? □Yes □No □Not applicable

11. In the last year, have you worried that the food you purchased would run out before you had money to buy more? □Yes □No □Declined to Answer

12. In the last year, did you run out of food and not have money to purchase more?

□Yes □No □Declined to Answer

If you answered **yes to the two questions above**, would you like information on community resources that can help?

□Yes □No