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Name of Patient _____ Sex (circle) M F Date of Birth _____
(First) (Middle) (Last)

Patient's Social Security Number _____ Primary Doctor _____

Mailing Address _____ City _____

State _____ Zip _____ Home Phone _____

Race: (Circle as many as you need) American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
Black or African Asian White Hispanic Other Pacific Islander Other Race Unreported/Refused to Report

Ethnicity: (Circle just one) Hispanic or Latino Not Hispanic or Latino Refused to Report

Father's Name _____ Date of Birth _____ Cell Number _____

Employer/Occupation _____ Work Number _____

Mother's Name _____ Date of Birth _____ Cell Number _____

Employer/Occupation _____ Work Number _____

FAMILY MEDICAL HISTORY

Please indicate if the patient's parents, grandparents, uncles, aunts or cousins have had any of the following:

Diabetes _____
Cancer _____
Tuberculosis _____
Convulsions _____
Heart disease _____
Kidney disease _____
Lung disease _____
Blood disease _____
Birth defects _____
Inherited disease _____
High blood pressure _____
Mental retardation _____
Mental disease _____
Jaundice / Liver disease _____
Alcohol / Drug Problems _____
Eczema _____
Hay Fever _____
Deafness _____
Asthma _____
Food allergies _____
Drug allergies _____

Names and birthdates of other children in the family:

_____
_____

PREGNANCY AND BIRTH

Was an obstetrician seen regularly during this pregnancy? _____ Doctor's Name _____
What was the month of first visit to the OB doctor? _____ When was baby due to be delivered? _____

During this pregnancy did any of the following occur? (Please indicate which month of pregnancy)

Gestational diabetes _____
Bleeding or spotting _____
Kidney trouble _____
Anemia _____
X-Rays _____
High blood pressure _____
Regular medications _____
Other medications _____
Cigarettes or alcohol _____
Operations _____
Hospitalizations _____
Rash or Fever _____

Weight Gain (how much) _____

Baby was delivered at _____ Hospital by (circle one) birth canal c-section
Did the baby need oxygen, resuscitation, or other special care in the delivery room? _____
Did the baby have any problems in the nursery? _____
How many days old was the baby when he/she went home from the nursery? _____
Did/Do you breastfeed? _____ How many months? _____