Joan White, MD
Keith Thompson, MD
Robin Pearson, MD

# Rivergate Pediatrics, PC

807 Meadowlark Lane
Goodlettsville, TN 37072
615-859-6650

Timothy Eidson, MD
Toni-Ann Wright, MD
Samantha Craighead, PA-C

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

Patient's Social Security Number __________________ Home Phone ____________________

Mailing Address ________________________________________ City ____________________

State ______ Zip ________ Primary Doctor Child will be seeing ______________________

| **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? ______________