

# PATIENT INFORMATION SHEET

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Total number of living children \_\_\_\_ Mother's age at birth \_\_\_\_  
Number of years between previous pregnancy & this child \_\_\_\_  
Prenatal Care Provider \_\_\_\_\_  
Trimester Prenatal Care Began: **1 2 3** Vitamins: **Y N** Iron: **Y N**  
\_\_\_\_ Term \_\_\_\_ Premature (\_\_\_\_ Weeks) \_\_\_\_ Overdue (\_\_\_\_ Weeks)  
\_\_\_\_ Vaginal \_\_\_\_ C-Section \_\_\_\_ Forceps  
\_\_\_\_ Breech \_\_\_\_ Multiple birth \_\_\_\_ Other

## MATERNAL COMPLICATIONS

\_\_\_\_ Vaginal bleeding \_\_\_\_ Anemia  
\_\_\_\_ Hyper tension \_\_\_\_ Rh negative  
\_\_\_\_ Diabetes \_\_\_\_ Premature labor  
\_\_\_\_ Injury/hospitalization/surgery \_\_\_\_ Flu-like illness or high temp.  
\_\_\_\_ Kidney or bladder infection \_\_\_\_ STDs  
\_\_\_\_ Hepatitis (A, B, or C) \_\_\_\_ Exposure to TB  
\_\_\_\_ Exposure to lead/chemicals \_\_\_\_ Dental disease

## NURSERY COURSE

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_  
\_\_\_\_ Difficulty with initial breathing  
\_\_\_\_ Hear t murmur  
\_\_\_\_ Infection  
Newborn blood screening (date/location):  
1. \_\_\_\_\_ 2. \_\_\_\_\_  
Newborn hearing test (in hospital): **Normal Abnormal**

## FEEDING & NUTRITION

Food Allergies \_\_\_\_\_  
Appetite usually good? **Yes No**  
Colic or feeding problems during the first 3 months? **Yes No**  
Breast fed? **Yes No** Number of months \_\_\_\_\_  
Formula? **Yes No** Current Brand \_\_\_\_\_  
Vitamins? **Yes No** Brand \_\_\_\_\_  
Special Diet? \_\_\_\_\_

## ALLERGIC REACTIONS

Medicine \_\_\_\_\_ Food \_\_\_\_\_  
Animals \_\_\_\_\_ Insect \_\_\_\_\_  
Immunizations up to date? **Yes No**  
Do you have the immunization record with you today? **Yes No**  
Medications taken on a regular basis? (exclude vitamins)

## CHILD'S MEDICAL HISTORY

Immunizations current: **Y N** Dental care/sealants current: **Y N**  
\_\_\_\_ Trauma/injuries \_\_\_\_ Hospitalizations  
\_\_\_\_ Surgery \_\_\_\_ Medications  
\_\_\_\_ Anemia \_\_\_\_ Early childhood caries  
\_\_\_\_ Hepatitis \_\_\_\_ Strep throat  
\_\_\_\_ Ear infections \_\_\_\_ Bladder/kidney infections  
\_\_\_\_ Pneumonia \_\_\_\_ Developmental delays  
\_\_\_\_ Vision problems \_\_\_\_ Hearing problems  
\_\_\_\_ Seizures \_\_\_\_ Allergies  
\_\_\_\_ Asthma \_\_\_\_ Eczema  
\_\_\_\_ Environmental toxin exposure (lead, etc.) \_\_\_\_ Substance use (alcohol, drug, tobacco)  
Other \_\_\_\_\_

## FAMILY PROFILE

PARENTS  Married  Separated  Divorced  
RELATION NAME DOB HEALTH  
Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Sibling \_\_\_\_\_  
Sibling \_\_\_\_\_  
Sibling \_\_\_\_\_  
Pets? \_\_\_\_\_ Smokers? \_\_\_\_\_

## FAMILY MEDICAL HISTORY

M - Mother F - Father S - Sibling  
PGM - Paternal Grandmother PGF - Paternal Grandfather  
PA - Paternal Aunt PU - Paternal Uncle  
MGM - Maternal Grandmother MGF - Maternal Grandfather  
MA - Maternal Aunt MU - Maternal Uncle  
\_\_\_\_ Anemia/blood disorder \_\_\_\_ Heart disease before age 50  
\_\_\_\_ Cholesterol req. treatment \_\_\_\_ Hyper tension/stroke  
\_\_\_\_ Asthma/allergy \_\_\_\_ Cancer  
\_\_\_\_ Diabetes \_\_\_\_ Epilepsy/seizures  
\_\_\_\_ Kidney problems \_\_\_\_ Muscle/bone disease  
\_\_\_\_ Genetic disea / maj birth defects \_\_\_\_ Childhood hearing impairment  
\_\_\_\_ Tuberculosis **Y N** HIV + individual in household  
\_\_\_\_ Other immunosuppression \_\_\_\_ Dental decay  
\_\_\_\_ Alcohol/drug abuse \_\_\_\_ Tobacco use  
\_\_\_\_ Learning disorder \_\_\_\_ Mental retardation  
\_\_\_\_ Psychiatric disorder \_\_\_\_ Phy/sexual/emotionl abuse  
\_\_\_\_ Domestic violence \_\_\_\_ Other

## DEVELOPMENT & BEHAVIOR

AT WHAT AGE CHILD  
Sat alone \_\_\_\_\_ Walked \_\_\_\_\_ Used sentences \_\_\_\_\_  
Toilet trained \_\_\_\_\_ Bicycled \_\_\_\_\_  
Grade in school \_\_\_\_\_ Getting along with other children **Yes No**  
Development compared to other children? \_\_\_\_\_  
Problems in school (learning/behavior) \_\_\_\_\_  
Bad habits \_\_\_\_\_  
Bedwetting? **Yes No** Nail biting? **Yes No**  
Sleeping? **Yes No** Use of street or illegal drugs? **Yes No**  
Hobbies \_\_\_\_\_

## ASSIGNMENT OF INSURANCE BENEFITS

*I hereby authorize direct payment of surgical/medical benefits to Huebner Pediatrics for services rendered by Dr. Gonzalez in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.*

## MEDICAID

*I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_