nataloni
Pediatrics P.C.

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## Patient Registration

| | | | | | |
|---|---|---|---|---|---|
| Legal Name | | DOB | | SSN | |
| Legal Name | | DOB | | SSN | |
| Legal Name | | DOB | | SSN | |

### Father

| | |
|---|---|
| Legal Name | |
| DOB | |
| SSN | |
| Street Address | |
| City | |
| State | |
| Postal Code / Zip Code | |
| Phone Number | |
| Work Phone | |
| Employer | |

### Mother

| | |
|---|---|
| Legal Name | |
| DOB | |
| SSN | |
| Street Address | |
| City | |
| State | |
| Postal Code / Zip Code | |
| Phone Number | |
| Work Phone | |
| Employer | |

### Insurance Information

| | | | | | |
|---|---|---|---|---|---|
| Primary Insurance | | | | Subscriber Name | |
| Member # | | Group # | | Subscriber SSN | |
| Claims Address | | | | | |
| Policy Type | | Co-pay amount | | | |

### Emergency Contact

| | |
|---|---|
| Name | |
| Phone | |
| Relationship | |

### Pharmacy

| | |
|---|---|
| Name | |
| City | |
| Phone | |
| Fax | |

# Initial History Questionnaire

NAME

ID NUMBER

Form Completed By

Date Completed

BIRTH DATE

AGE

M F

## Household

Please list all those living in the child's home.

| Name | Relationship To child | Birth Date | Health Problems |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there siblings not listed? If so, please list their names and ages and where they live.

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

## Birth History

Birth weight

Was the baby born at term? Early? Late?

If early, how many weeks' gestation?

Did mother have any illness or problem with her pregnancy?
Yes No Explain

During pregnancy, did mother
Smoke Yes No Drink Alcohol Yes No
Use drugs or medications Yes No
What When

Was the delivery Vaginal? Cesarean?
If cesarean, why?

Did your baby have any problems right after birth?
Yes No Explain

Was initial feeding Breast? Bottle?

Did your baby go home with mother from the hospital?
Yes No Explain

## General

Do you consider your child to be in good health? Yes No Explain

Does your child have any serious illness or medical condition? Yes No Explain

Has your child had serious injuries or accidents? Yes No Explain

Has your child had any surgery? Yes No Explain

Has your child ever been hospitalized? Yes No Explain

Is your child allergic to any medicine or drugs? Yes No Explain

## Development

Are you concerned about your child's physical development? Yes No Explain

Are you concerned about your child's mental or emotional development? Yes No Explain

Are you concerned about your child's attention span? Yes No Explain

**If your child is in school:**

How is his/her behavior in school?

Has he/she failed or repeated a grade in school?

How is he/she doing in academic subjects?

Is he/she in special or resource classes?

## Family History

**Have any family members had the following:**

| | | | | |
|---|---|---|---|---|
| Deafness | ○ Yes | ○ No | Who _____ | Comments _____ |
| Nasal allergies | ○ Yes | ○ No | Who _____ | Comments _____ |
| Asthma | ○ Yes | ○ No | Who _____ | Comments _____ |
| Tuberculosis | ○ Yes | ○ No | Who _____ | Comments _____ |
| Heart disease (before 50 years old) | ○ Yes | ○ No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | ○ Yes | ○ No | Who _____ | Comments _____ |
| High cholesterol | ○ Yes | ○ No | Who _____ | Comments _____ |
| Anemia | ○ Yes | ○ No | Who _____ | Comments _____ |
| Bleeding disorder | ○ Yes | ○ No | Who _____ | Comments _____ |
| Liver disease | ○ Yes | ○ No | Who _____ | Comments _____ |
| Kidney disease | ○ Yes | ○ No | Who _____ | Comments _____ |
| Diabetes (before 50 years old) | ○ Yes | ○ No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | ○ Yes | ○ No | Who _____ | Comments _____ |
| Epilepsy or convulsions | ○ Yes | ○ No | Who _____ | Comments _____ |
| Alcohol abuse | ○ Yes | ○ No | Who _____ | Comments _____ |
| Drug abuse | ○ Yes | ○ No | Who _____ | Comments _____ |
| Mental illness | ○ Yes | ○ No | Who _____ | Comments _____ |
| Mental retardation | ○ Yes | ○ No | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | ○ Yes | ○ No | Who _____ | Comments _____ |

Additional family history _____

## Past History

**Does your child have, or has he/she ever had:**

| | | | |
|---|---|---|---|
| Chickenpox | ○ Yes | ○ No | When _____ |
| Frequent ear infections | ○ Yes | ○ No | Explain _____ |
| Problems with ears or hearing | ○ Yes | ○ No | Explain _____ |
| Nasal allergies | ○ Yes | ○ No | Explain _____ |
| Problems with eyes or vision | ○ Yes | ○ No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | ○ Yes | ○ No | Explain _____ |
| Any heart problem or heart murmur | ○ Yes | ○ No | Explain _____ |
| Anemia or bleeding problem | ○ Yes | ○ No | Explain _____ |
| Blood transfusion | ○ Yes | ○ No | Explain _____ |
| Frequent abdominal pain | ○ Yes | ○ No | Explain _____ |
| Constipation requiring doctor visits | ○ Yes | ○ No | Explain _____ |
| Bladder or kidney infection | ○ Yes | ○ No | Explain _____ |
| Bed-wetting (after 5 years old) | ○ Yes | ○ No | Explain _____ |
| (For girls) Has she started her menstrual periods? | ○ Yes | ○ No | When _____ |
| (For girls) Are there problems with her periods? | ○ Yes | ○ No | Explain _____ |
| Any chronic or recurrent skin problems (acne, eczema, etc.) | ○ Yes | ○ No | Explain _____ |
| Frequent headaches | ○ Yes | ○ No | Explain _____ |
| Convulsions or other neurologic problems | ○ Yes | ○ No | Explain _____ |
| Diabetes | ○ Yes | ○ No | Explain _____ |
| Thyroid or other endocrine problem | ○ Yes | ○ No | Explain _____ |
| Any other significant problem | ○ Yes | ○ No | Explain _____ |
| Use of alcohol or drugs | ○ Yes | ○ No | Explain _____ |