Dyson Pediatrics MRN: _____

Duane Dyson, MD, FAAP Elizabeth Altomare, MD, FAAP

Patient Name:	Birth Date	Age	Sex M F
Mother's Name:	Father's Name:	Forms Completed By:	Date

Household Information

Name	Relation to Child	Birth Date	Health Problems	Occupation

Social History

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

Does the child have access to a pool? Is it fenced or covered? ( )yes ( )no
Explain_____

What languages are spoken in home? ( ) English ( ) Spanish ( )Other_____

Childcare? ( )Parents ( )Relatives ( )Daycare ( )Babysitter/Nanny

Days per week at daycare (not with parents)_____

Do any household members smoke? ( )yes ( )no

Birth History

Did mother have any illness or problems with pregnancy? ( )yes ( )no Explain_____

During the pregnancy did mother use medications, drugs, smoke or drink alcohol?
( )yes ( )no Explain_____

Was the delivery ( ) Vaginal? ( ) C-section?

Was the baby ( ) Term? ( ) Early?

Gestational Age? _____weeks

What was the baby's birth weight _____ lbs ____ oz

Did your baby have any problems right after birth?

( )yes ( )no Explain_____

Did your baby pass the hearing screen?

( )yes ( )no Explain_____

Did your baby get the Hepatitis B vaccine?

( )yes ( )no Explain_____

Did your baby go home with mother from the hospital? ( )yes ( )no Explain_____

General Information

Does your child see any specialists?

( )yes ( )no Explain_____

Does your child have any serious illness or medical condition?

( )yes ( )no Explain_____

Has your child had any serious injuries or accidents?

( )yes ( )no Explain_____

Has your child had any surgeries?

( )yes ( )no Explain_____

Dyson Pediatrics MRN: _____

Duane Dyson, MD, FAAP Elizabeth Altomare, MD, FAAP

Does your child use any medical devices?

( )yes ( )no Explain_____

Is your child allergic to any medications or foods?

( )yes ( )no Explain_____

Has your child been hospitalized?

( )yes ( )no Explain_____

Are your child's immunizations up to date?

( )yes ( )no ( ) I don't know

Medications

Name_____ Dose_____ Frequency_____

Name_____ Dose_____ Frequency_____

Developmental

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_____

Family History

Condition	Mother	Father	Sibling	Grandparent	Comments
Asthma					
Anemia					
Blood Disorder					
Cancer					
Heart Attack/Disease					
High Cholesterol					
High Blood Pressure					
Stroke					
Liver Disease					
Kidney Disease					
Diabetes					
Epilepsy or Convulsions					
Mental Illness (Anxiety, Depression)					
Mental Retardation					
Thyroid Disease					
Sudden Death					
Immune Problems					