

NEW PATIENT: PLEASE GIVE A NURSE/DOCTOR A COPY OF YOUR CHILDS VACCINE HISTORY.

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

PREGNANCY & DELIVERY:

Place of Birth (Name of Hospital or Birthing Center) _____

Pregnancy Problems _____

Type of Delivery (Vaginal or C-Section) _____

Birth Weight _____ Birth Length _____ Apgar Screens _____

Newborn Problems _____

DEVELOPMENT: (age if known or put early, normal, etc) For children ages 5 & under only.

Held Up Head _____ Rolled Over _____

Sat Alone _____ Crawled _____

Walked Holding On _____ Walk Alone _____

Runs _____ First Words _____

Potty Trained _____

HOME ENVIRONMENT/SAFETY:

Smoker/Active/Passive	Yes	No	Type of Heat _____	Yes	No
Pets	Yes	No	Hot Water Temperature <120°	Yes	No
Smoke Detectors/Carbone Monoxide Detector	Yes	No	Firearms/Storage/Removal Locked & unloaded	Yes	No
Pool/Fence	Yes	No	Dental Care 2x yr	Yes	No
Sun/Exposure	Yes	No	Child Auto Safety	Yes	No
Injury Prevention- Window/Stair Guards	Yes	No	Lead Exposure-house built prior To 1960	Yes	No
Bicycle/Motorcycle/ATV Safety helmets	Yes	No	Healthy Diet >5 Fruits/veggies/day	Yes	No
Alcohol/Drug Use Chemical Dependency	Yes	No	Drug/Poison Storage/Poison Control	Yes	No
STD/HIV	Yes	No	Choking/CPR Training	Yes	No
Contraception	Yes	No	Physical Activity >3 x/wk	Yes	No