



249 Route 94  
 PO Box 739  
 Vernon, NJ 07462  
 PH: (973) 827-4550  
 FX: (973) 827-5845

Gurbir S. Saluja, MD  
 Manmohan K. Saluja, MD  
 Gurmit S. Saluja, MD  
 Diana Huzar, DO

**Patient Information**

<b>PATIENT NAME</b> (Last, First)		<b>Date of Birth</b>	<b>Date of Initial Visit</b>
<b>MOTHER'S NAME</b>		<b>FATHER'S NAME</b>	

**LEGAL GUARDIAN** (if other than Biological Mother or Father)

**Patient Birth History / Past Medical History**

<b>Maternal Age at Pregnancy</b>	<b>Length of Pregnancy</b>	<b>Hospital of Birth</b>	<b>Obstetrician</b>
<b>Type of Delivery</b> <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	<b>Med/Drug Use During Pregnancy</b> <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Other (explain) _____	<b>APGAR</b> _____/_____	<b>Birth Weight / Ht. / HC</b> Weight    Height    Head Circ.
<b>Feeding</b> <input type="checkbox"/> Breast <input type="checkbox"/> Formula			

Problems During Pregnancy / Labor / Delivery / Nursery Stay?

Please check all conditions that may apply to the above mentioned patient:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers / Bowel Disorder
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Alcoholism / Drug Abuse
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Prematurity	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma

Other / Explain Below:

<b>Chronic Illness</b>	<b>Surgery / Hospitalization</b>	<b>Allergies</b>
------------------------	----------------------------------	------------------

**Family Medical History**

Name	Date of Birth	Allergy	Illness / Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			

Please check all conditions that apply to all members of the family (immediate and extended) and describe below:

<input type="checkbox"/> Asthma / Allergies	<input type="checkbox"/> Headaches	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ulcers / Bowel Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Alcoholism / Drug Abuse	<input type="checkbox"/> Mental Illness

Other (please explain):

**Social History**

Any concerns / problems in school?

Any pets?

Any tobacco use by household members?

Any travel outside the country in the past year?