

Field Pediatrics, P.C.
1106 Gleneagles Drive
Huntsville, Al 35801

Race: (please circle)
White Black
Asian Hispanic
Other

I. GENERAL INFORMATION

- A. Child's Name _____ Nickname _____ Sex M F
(Last) (First) (Middle) (Circle)
- B. Date of Birth _____ Place of Birth _____
- C. School (or daycare) Attending _____ Grade _____
- D. Child's Previous Physician _____ Obstetrician _____
- E. Child's Primary Caretaker: () Parents () Mother () Father Other _____
- F. Child's Home Address _____
City _____ State _____ Zip _____
Home Phone () _____ Other Non-work Phone () _____
Relationship _____
- G. Father's Name _____ Date of Birth _____
(Last) (First) (Middle)
Marital Status: M S D W
Employed By: _____ How Long? _____
Occupation _____ S.S. # _____
Business Address: _____
Business Phone #: () _____ Cell Phone #: () _____
Home Address If Different From Child's _____
- H. Mother's Name _____ Date of Birth _____
(Last) (First) (Middle)
Marital Status: M S D W
Employed By: _____ How Long? _____
Occupation _____ S.S. # _____
Business Address: _____
Business Phone # () _____ Cell Phone # () _____
Home Address If Different From Child's _____
- I. Other Adult in Home _____ Date of Birth _____
(Last) (First) (Middle)
Relationship to Child _____
Home Address If Different From Child's _____
Home / Business Phone # () _____ / _____ Cell Phone # () _____
- J. If you have lived in this area less than one year, what was your previous address? _____

- K. Person Responsible for account: _____ Relationship _____
- L. Insurance Carrier _____ Contract # _____
Secondary Insurance _____ Contract # _____
- M. Who referred you to us? _____

II. BIRTH HISTORY: Circle "Yes" or "No", or the correct words, fill in blanks, and explain any "Yes" answers below.

- A. Did mother smoke, drink alcohol, or take any medications during the pregnancy? Yes / No
 - B. Were there any problems during the pregnancy? Yes / No
 - C. Your child was born _____ weeks early / late, or within one week of expected?
 - D. Were there any problems with the delivery? Yes / No Birth Weight? _____ # _____ oz
 - E. Type of delivery: Vaginally head first or breach; or by C-Section?
 - F. Were there any problems during the newborn hospital stay? Yes / No
 - G. Your child stayed _____ days in the hospital before coming home?
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III. DEVELOPMENTAL HISTORY: Rolled over at _____ months; Sat at _____ months; Crawled at _____ months; Cruised (walking holding onto things) at _____ months; Walked at _____ months; Meaningful Words at _____ months; 3 Word Sentences by _____ months; Toilet trained by _____ months; School Performance _____

IV. FAMILY HISTORY:

Sibling names: _____

Age / Sex _____ / _____ _____ / _____ _____ / _____

Birth Date _____

If any family members (including this child) have or had the following problem (s), check and explain below. You may abbreviate relations to patient as follows: F for father, M for mother, PGM for paternal (father's) grandmother, MGF for maternal (mother's) grandfather, MA for maternal aunt, MU for maternal uncle, etc.

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|---|---|--|
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Eczema / Skin Disease |
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Liver Disease / Jaundice | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Muscle or Bone Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Growth Disorders | <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hay Fever or Allergies | <input type="checkbox"/> Free Bleeder |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Drug Allergy or Reaction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other |
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