Phoenix Perinatal Associates

OBSTETRIX MEDICAL GROUP

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NEW PATIENT INFORMATION

Name_____DOB_____

REASON FOR REFERRAL/EVALUATION:

_____

_____

_____

Referred by_____

BIRTH/PREGNANCY HISTORY

Birth weight_____ Length of Pregnancy (weeks)_____

Complications during pregnancy?_____

_____

During the pregnancy was there:

Smoking_____ Alcohol consumption_____ Drug use_____

_____

Delivery:

Induced_____ C-section_____ Breech_____ forceps_____

Length of hospital stay if baby stayed longer than the mother:

_____

What were the reasons for the extended stay?

_____

_____

_____

Were there any issues during the first month at home?_____

_____

MEDICAL HISTORY

Immunizations Up to date_____

If not, reasons:_____

HAS YOUR CHILD EVER HAD:

Health	**Yes**	**No**	**Ages**	**Details**
Ear Infections				
PE tubes				
Seizures				
Fevers with viruses				
Trouble eating				
Special diets				
Skin problems				
Other				
Constipation				
Trouble hearing				
Trouble seeing				

Does your child have any allergies?_____

Has your child been evaluated by physicians other than their pediatrician or PCP?

_____

_____

_____

_____

_____

Is your child taking any medications?

_____

_____

_____

_____

_____

Has you child had any previous hospitalizations, injuries or surgeries?

_____

_____

_____

_____

_____

At what age did your child meet these milestones?

Roll over _____ Smile_____

Sat alone _____ Drink from a cup_____

Army Crawl _____ Crawl hands and knees _____

Walked holding on to furniture____ Walked without help_____

Toilet trained_____ Talk in short phrases _____

DOES YOUR CHILD:

	YES	NO	COMMENTS/ EXAMPLE/ AGE
Dislike getting hands dirty			
Over-react to touch			
Over react to certain odors			
Over react to certain lights			
Over react to noises			
Dislike going barefoot			
Dislike wearing shoes			

Dislike wearing clothes			
Dislike having teeth brushed			
Dislike swinging			
Seem attracted to touch things in an unusual fashion			
Seem attracted to smell things unusually			
Seem to taste taste things that aren't food			
Seem pre-occupied with particular objects or activities			

HAS YOUR CHILD EVER HAD THESE BEHAVIORS?

	YES	**NO**	**COMMENTS/ AGE**
Irritability			
Colic			
Trouble keeping to schedule			
Sleep problems			
Rocking in bed			
Head banging			
Temper tantrums			

Breath holding			
Repetitive body movements			
Overactive			
Short attention span			
Mood changes			
Aggressive behavior			
Shyness with others			
Crying easily and often			
Very sensitive			
Poor eye contact			
Difficult to comfort			
Not cuddly or affectionate			
Difficulty in adapting to change in routine			

Please describe any other behavioral issues with your child:

_____

_____

_____

FAMILY HISTORY

Please list the names, ages and relationship of others living in the home:

Name	Relationship	Age

List members of the immediate family not living at home, where living, and reason:

_____

_____

Language/languages spoken in home_____

Section: Parents

	MOTHER	FATHER
School level completed		
Present occupation		
Age		
Health problems		

Has there been any extended family history of the following in aunts, uncles, cousins, grandparents? Please check/list condition and the relationship to your child.

	Condition	Relationship to child
	Cancer	
	Diabetes	
	Asthma	
	Heart problems	
	Hearing	
	Neurological problems	
	Aggressiveness	
	Anger	
	ADHD	
	Learning Disabilities	
	School problems	
	Substance abuse	
	Depression	
	Anxiety	
	Issues similar to your child	

Who cares for your child during the day?_____

List any pets in your house:_____

Has your child had any **special evaluations or testing done**? If so, please list type of testing or specialist, and when and where evaluation was done. Also list any therapies (physical, speech, occupational, emotional or behavioral and when/where). If possible, please bring copies of these to the visit.

_____

_____

_____

_____

_____

List daycare/preschools/mother's day out/ other schools attended:

Name of Program or School: Dates:

_____

_____

_____

_____

_____

Describe any special help the child is presently receiving:

_____

_____

_____

ACTIVITIES

Which does your child like to do? _____

_____

_____

What activities has your child been involved in?

_____

_____

What has been difficult about parenting your child?_____

_____

_____

_____

What do you enjoy most about your child?_____

_____

_____

_____

Does your child have special talents/interests? _____

_____