Today's Date: _____-_____-_____

Cradle thru College Care
Pediatrics

Patient's Full Name: _____ **Sex**: _____ **DOB**: _____-_____-_____

Any known allergies? Yes _____ No_____

Please list medications/ food and reaction: _____

_____

_____

Any health concerns? Yes _____ No_____

If yes, please describe: _____

_____

Hospital or city of birth: _____

Full Term? Yes _____ No_____ If no then: Gestational age (# of weeks): _____

Birth Weight: _____pounds _____ounces **Birth Length**: _____ inches

Were there any problems during delivery? Yes _____ No_____

If yes, describe: _____

_____

Were there any problems in the nursery? Yes _____ No_____

If yes, describe: _____

_____

Infant Feedings

Breast Milk?: Yes _____ No_____ How Long: _____

Formula?: Yes _____ No_____ How Long: _____ Type of formula used: _____

Current Diet (circle all that apply): Breast / Formula / Baby Food / Table Food / Whole Milk / 2% Milk / Skim Milk

Family Health History

	Yes	No	Relationship to Patient
Asthma?			
Bleeding Problems?			
Cancer?			
Cystic Fibrosis?			
Depression?			
Diabetes?			
Eating Disorders?			
Hay fever?			
Heart Attack?			
Heart Defect at Birth?			
Hemophilia?			
High Blood Pressure?			
High Cholesterol?			
Muscular Dystrophy?			
Other Birth Defects?			
Seizures?			
Sickle Cell Anemia?			
Sickle Cell Trait?			
Spleen Removal?			
Stroke?			
Unexplained Death?			
Other?			