ALEXANDRIA PEDIATRIC GROUP

PRENATAL INFORMATION

Infant's Last Name:_____ Due Date:_____

Obstetrician:_____ Hospital:_____

Mother's Name:_____ Age:_____ Father's Name:_____

Number of Pregnancies, Including Present:_____ Living Children:_____ Miscarriages:_____

Family Address:_____ Telephone:_____

_____ Work or Cell #:_____

E-mail Address:_____ Pharmacy:_____

Insurance:_____ Member #:_____ Group:_____

Mother's Medical History Referred to Us By:_____

A. This Pregnancy

1. Special Problems

Fever_____ High Blood Pressure_____ Rashes_____ Diabetes_____ Infections_____

Other_____ Bleeding_____ Excess Weight Gain_____

2. Medications/Drugs Taken During Pregnancy and When:_____

_____

_____

3. X-Rays or Injury During Pregnancy and When:_____

_____

4. Blood Type/RH: Mother:_____ Father:_____

5. Cesarean Section Planned: Yes_____ No_____ Reason_____

B. Previous Pregnancies

Year of Birth	Sex	Birth Weight	Special Problems
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

C. Past Medical History: (List significant illnesses, surgery, injuries, hospitalization, allergies, etc.)

_____

_____

D. Family Medical History: (List conditions of possible importance in the care of your family, such as, diabetes, frequent miscarriages, epilepsy, bleeding disorder, serious anemia, muscular disorder, newborn with serious difficulties, twins, etc.)

_____

_____

_____

E. Plans for Labor, Delivery, Etc....

1. Comments regarding childbirth classes, father's participation, labor & delivery, preferred anesthesia, etc:

_____

_____

2. Feedings: Breast_____ Bottle_____ Undecided_____

3. Male Infant - Circumcision: Yes_____ No_____ Undecided_____

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

HEALTH HISTORY

Minor/Child's Previous Physician _____

Date of last physical examination _____ Results _____

	YES	NO
Receiving any medication or drugs? _____	☐	☐
Has your child been hospitalized? _____	☐	☐

Medications _____

Date Reason Hospital

_____

_____

Allergies To Drugs/Food _____

HAS MINOR/CHILD HAD ANY HISTOR OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Convulsions/Seizures	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bleeding, excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Other
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other
☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever	☐	☐	Other

IMMUNIZATIONS

Up to date: Yes No

Please provide us with proof of immunizations.

PERSONAL

Other family members that are patients here: _____

_____

Childs hobbies _____

Likes _____ Dislikes _____

Sports _____ School/Daycare _____

We would like to thank you for putting your trust in us in treating your child/children. If you were referred by a friend or relative we would like to thank them.

Referred by _____

or were you referred by ____ **Phone Book** ____ **Advertisement** ____ **Other:** _____

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PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Initial

Sex ☐ M ☐ F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____ Home Phone _____ Work Phone _____

Cell phone Cell phone
Mom _____ Dad _____ Relative # _____ Name _____

INSURANCE COVERAGE

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____
(if different from above) (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate _____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

_____

Group# _____

Policy# _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____
(if different from above) (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate _____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

_____

Group # _____

Policy# _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia - Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other _____
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease			_____

(OVER)