SCHWARTZ PEDIATRICS SC

PATIENT NAME: _____

DATE OF BIRTH: _____

ETHNICITY:	**CHECK MOST APPROPRIATE**	
☐ AFRICAN AMERICAN	☐ CAUCASIAN	☐ OTHER
☐ ASIAN	☐ HISPANIC	_____

SOCIAL HISTORY:	**CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS**	
CHILD BREASTFED?	YES	NO
SMOKERS IN THE HOUSE?	YES	NO
CATS IN THE HOUSE?	YES	NO
DOGS IN THE HOUSE?	YES	NO
CHILD IN DAY CARE?	YES	NO
PARENTS DIVORCED?	YES	NO
PARENTS SEPARATED?	YES	NO

BIRTH HISTORY:

NAME OF HOSPITAL YOU DELIVERED AT:_____

WHICH DOCTOR SAW YOUR BABY IN THE HOSPITAL? DR. DAVE DR. ELIE OTHER

BABY #	BIRTH WEIGHT
TERM	PREMATURE (# OF WEEKS)
BREAST	FORMULA
VAGINAL	C-SECTION

COMPLICATIONS DURING NURSERY STAY: NONE

_____

_____

_____

SCHWARTZ PEDIATRICS SC

PATIENT NAME: _____

DATE OF BIRTH: _____

PAST MEDICAL HISTORY:

PREVIOUS HOSPITALIZATIONS: (DATE & DIAGNOSIS) NONE

_____

_____

_____

PREVIOUS SURGERIES: (DATE & PROCEDURE) NONE

_____

_____

_____

PREVIOUS FRACTURES: (DATE & SITE) NONE

_____

_____

_____

CURRENT MEDICATIONS: (DOSAGE & FREQUENCY) NONE

_____

_____

_____

DRUG ALLERGIES: NONE

_____

_____

_____

IMMUNIZATION HISTORY:

THE OFFICE MUST HAVE A COPY OF YOUR CHILD'S VACCINE RECORD TO ASSURE OPTIMAL CARE