



Maria A. Lopez, MD, FAAP  
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**Prenatal Appointment Date & Time:** \_\_\_\_\_ **Provider:** \_\_\_\_\_

**Babies Gender:** \_\_\_\_\_ **Due Date:** \_\_\_\_\_ **Hospital:** \_\_\_\_\_ **OBGYN:** \_\_\_\_\_

**Mothers Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Insurance:** \_\_\_\_\_

**How Did You Hear About Us?** \_\_\_\_\_

**Questions or Concerns:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### PAST MEDICAL HISTORY

Birthplace (Hospital) \_\_\_\_\_ Birth weight \_\_\_\_\_ Length \_\_\_\_\_ Head Circumference \_\_\_\_\_

Birth Complications: \_\_\_\_\_ Neonatal ICU: Y N

**FAMILY HISTORY** (If positive, give relationship to child-M, F, S, B, MGM, MGF, PGM, PGF):

|                                                          |                                                        |
|----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD                        | <input type="checkbox"/> Heart Disease                 |
| <input type="checkbox"/> Alcohol/Substance Abuse         | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Infant Death                  |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Kidney Disease/UTI            |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Learning/ School Difficulties |
| <input type="checkbox"/> Birth defects                   | <input type="checkbox"/> Mental Illness                |
| <input type="checkbox"/> Bleeding/ Blood Disorders       | <input type="checkbox"/> Mental Retardation            |
| <input type="checkbox"/> Bone/Joint Disorders            | <input type="checkbox"/> Migraine Headaches            |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Nerve/Muscle Disorders        |
| <input type="checkbox"/> Cholesterol Elevation           | <input type="checkbox"/> Obesity                       |
| <input type="checkbox"/> Cystic Fibrosis                 | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Skin Disorders                |
| <input type="checkbox"/> Down Syndrome                   | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Epilepsy/Seizures               | <input type="checkbox"/> Sudden Death                  |
| <input type="checkbox"/> Hearing Loss                    | <input type="checkbox"/> Thyroid Disease               |
| <input type="checkbox"/> Heart Attack < 55yrs male _____ | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> < 65 yrs female _____           | <input type="checkbox"/> Other                         |

### SOCIAL HISTORY

Breastfed or bottle:

Parents' marital status:

Child lives with:

Animals: Y N Type: \_\_\_\_\_

Smoke exposure: Y N

Smoke/CO Detectors in home: Y N

Seatbelt/Car seat used routinely: Y N

Sunscreen used routinely: Y N

Insect repellent used routinely: Y N

Guns present in home: Y N

Pool at home: Y N

Parent(s) Occupation: (please indicate which parent)

Parents born in foreign country: Y N

If yes, name of country: \_\_\_\_\_

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