San Diego Uptown Pediatrics

3500 5th Avenue, Suite 101
San Diego, CA 92103
Tel: (619) 295-3911
Fax: (619) 295-4356

New Patient History

Child's Name _____

Date of Birth _____ **Today's Date:** _____

Ethnicity □ Hispanic □ Non-Hispanic □ Decline to Specify

Race □ American Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White □ Decline to specify □ Other _____

Birth History

Hospital: _____

Delivery type □ Vaginal □ Cesarean Were forceps or a vacuum used?_____

If a C-section was performed, what was the reason?_____

Maternal blood type_____ Baby's blood type (if known)_____GBS status_____

Birth weight_____ Birth length_____ APGARs _____

	Yes	No
Were fertility treatments or assisted reproductive techniques used for conception?	□	□
Were there any complications during the pregnancy or delivery?	□	□
Were any medications taken during pregnancy?	□	□
Was your baby exposed to alcohol, tobacco, or recreational drugs?	□	□
Was your baby born more than 2 weeks prior to the due date?	□	□
Did your baby spend any time in the NICU?	□	□
Was your baby jaundiced?	□	□
Did your baby have any difficulties at birth?	□	□

If you answered "yes" to any of the above, please explain: _____

_____

_____

Past Medical History

Most recent check-up_____ Name of previous physician_____

Chronic medical conditions_____

Current medications_____

Medication allergies_____

Food allergies_____

Environmental allergies (e.g. dust mite, animals, pollen)_____

Are your child's immunizations up to date?_____

	Yes	No
Has your child been diagnosed with any medical conditions?	□	□
Has your child ever been admitted to the hospital?	□	□
Has your child had any surgeries?	□	□
Has your child had any serious injuries?	□	□
Has your child ever been seen by a specialist?	□	□
Has your child received any therapies (e.g. OT, PT, speech therapy)?	□	□

If you answered "yes" to any of the above, please explain_____

_____

_____

_____

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Biological Family History

Have any family members had the following?

	Yes	No	Family member (specify maternal or paternal), provide details
Asthma	▢	▢	_____
Environmental Allergies	▢	▢	_____
Food Allergies	▢	▢	_____
Childhood Hearing Loss	▢	▢	_____
Tuberculosis	▢	▢	_____
Heart Attack (before age 50)	▢	▢	_____
Congenital Heart Disease	▢	▢	_____
High Cholesterol	▢	▢	_____
Anemia	▢	▢	_____
Bleeding or Clotting Disorder	▢	▢	_____
Cancer	▢	▢	_____
Liver Disease	▢	▢	_____
Kidney Disease	▢	▢	_____
Diabetes	▢	▢	_____
Epilepsy or Seizures	▢	▢	_____
Autoimmune Disease	▢	▢	_____
Celiac Disease	▢	▢	_____
Inflammatory Bowel Disease	▢	▢	_____
Thyroid Disease	▢	▢	_____
Sickle Cell	▢	▢	_____
Blindness	▢	▢	_____
Hip Dysplasia	▢	▢	_____
Compromised Immune System	▢	▢	_____
Developmental Disability	▢	▢	_____
Autism	▢	▢	_____
Mental Illness	▢	▢	_____
Other	▢	▢	_____

Social History

Parent name_____Occupation_____

Parent name_____Occupation_____

Child's siblings' names and dates of birth_____

_____

Who lives at home with your child? _____

_____

Are parents divorced or separated? If "yes", what is the custody arrangement? _____

_____

Is there anything else you would like us to know about your child and family? _____

_____

Form completed by _____

Relationship to child _____Date_____