Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please arrive 30 minutes before your appointment time.

Your visit will take approximately one hour to complete.

**Where was your child born?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who was your Obstetrician or Nurse midwife? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Family History for Patient** | **Deceased?****At what age:**  | **Health problems (As an adult or a child) Including cause of death** |
| **Mother** |  |  |
| **Father** |  |  |
| **Sister** |  |  |
| **Brother** |  |  |
| **Maternal Aunt** |  |  |
| **Maternal Uncle** |  |  |
| **Paternal Aunt** |  |  |
| **Paternal Uncle** |  |  |
| **Maternal Grandmother** |  |  |
| **Maternal Grandfather** |  |  |
| **Paternal Grandmother** |  |  |
| **Paternal Grandfather** |  |  |

|  |
| --- |
| **Social History:** |
| Siblings: Ages  |  |
| Parent’s Occupation(s): |  |
| If applicable: If dual households, which parent has legal medical decision making authority? |  |
| If dual households, what is the average time spent at each household? |  |
| Pets: |  |
| Smoking at home (include smoking outside) |  |
| Preferred name of the child |  |