CHART # _____

CHILDREN'S CLINIC OF PASCAGOULA

PLEASE FILL FORM OUT TO THE BEST OF YOUR KNOWLEDGE

PATIENT NAME LAST	FIRST	MIDDLE	GENDER	BIRTH DATE / /	RACE	DATE FIRST SEEN / /

HOSPITAL WHERE BORN	REASON FOR VISIT:
MOTHER'S NAME	BROUGHT BY:
FATHER'S NAME	**PARENTS MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED**

FAMILY HISTORY (Immediate Family)

	AGE	
MOTHER		MISCARRIAGES ❒ YES How Many?_____ ❒ NO
FATHER		TUBERCULOSIS ❒ YES ❒ NO
SIBLING		SEIZURES/EPILEPSY ❒ YES ❒ NO
SIBLING		DIABETES ❒ YES Type_____ ❒ NO
SIBLING		HIGH BLOOD PRESSURE ❒ YES ❒ NO
SIBLING		HEART DISEASE ❒ YES ❒ NO
SIBLING		CANCER ❒ YES Type_____ ❒ NO
SIBLING		KIDNEY DISEASE ❒ YES ❒ NO

PAST MEDICAL HISTORY

Has the child ever been hospitalized?
❒ YES ❒ NO If yes, please list

DATES	REASON
/ /	
/ /	
/ /	

DOES THE CHILD HAVE ANY PREVIOUS DIAGNOSES? PLEASE LIST

BIRTH HISTORY

HOW MANY WEEKS WERE YOU PREGNANT?_____ DELIVERY: ❒ VAGINAL ❒ C-SECTION

BABY'S BIRTH WEIGHT: _____

BABY'S DIET: ❒ FORMULA ❒ BREAST HOW MANY OUNCES?_____ HOW OFTEN ARE FEEDINGS? _____

ANY DIFFICULTIES DURING PREGNANCY? ❒ YES ❒ NO IF CHECKED YES, PLEASE LIST:

ALLERGIES TO MEDICATIONS OR FOOD? ❒ YES ❒ NO IF CHECKED YES, PLEASE LIST:

ANYONE IN THE HOME SMOKE ❒ YES Who?_____ ❒ NO

WILL THE CHILD BE IN DAYCARE? ❒ YES ❒ NO