

Patient Information Update Form

Patient Name: _____ **Birthdate:** _____

Welcome to our Practice! The information in this questionnaire is an important part of your child's medical record. The information is kept confidential. Please answer each question carefully. If you need assistance, ask the nurse or doctor. We may ask you to update this information periodically.

MOTHER/BABY MEDICAL HISTORY:

1. Birth Weight: _____
2. Pregnancy Lasted to full term (___) or pre term (___) and/or # of weeks _____
3. Type of delivery: Vaginal or C-Section
4. Mother's age at time of birth: _____ Number of pregnancies: _____ Number of deliveries: _____
5. Ever had bladder/kidney infection? **Y N** (If yes at what age? ___) Ever had wheezing? **Y N** (If yes at what age? ___)
6. Any medical problems? **Y N** Specify: _____
7. Fractures, concussions, or other serious injury? **Y N** Specify (include age): _____
8. Allergies: **Y N** (If yes, please specify): _____
9. Patient Surgeries or hospitalizations (where the patient was admitted to the hospital):

Age: _____ Reason: _____
Age: _____ Reason: _____
Age: _____ Reason: _____

10. Please list all household members:

_____	_____
_____	_____
_____	_____

10. FAMILY AND SOCIAL HISTORY:

A.) Mom and Dad: Married Divorced Separated Never Married

If the parents live in different homes, does the child visit the other parent? **Y N**

B.) Does any member of the household smoke? **Y N** If "yes" **Inside or Outside**

C.) Animals in the home? **Y N** If "yes" give the type of animal(s) _____

D.) Heat with wood stove or fireplace? **Y N**

E.) Drug or Alcohol problems at home? **Y N**

