

# Stepping Stone Pediatrics, LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last Name First Name Middle

Child's Nickname: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex:  Male  Female

Child's Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

## Mother's Information

Name: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ SS# \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Phones: work \_\_\_\_\_ cell \_\_\_\_\_

## Father's Information

Name: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ SS# \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Phones: work \_\_\_\_\_ cell \_\_\_\_\_

Please list all those living in the child's home.

Name	Relationship to child	Age	Health Problems	Is there a smoker living in the child's home? <input type="checkbox"/> Yes <input type="checkbox"/> No Whom? _____
				If mother and father are not living together, with whom does the child live?  _____

## Birth History

Birth Weight _____ Apgar _____ At how many weeks gestation was the baby born? _____ Did mother have regular prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No Did mother have any illness or problem with her pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ <hr/> During pregnancy, did mother: Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No Drink alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Use drugs or medication <input type="checkbox"/> Yes <input type="checkbox"/> No What _____ When _____	Was the delivery <input type="checkbox"/> Vaginal? <input type="checkbox"/> Caesarean? If cesarean, why? _____ Did your baby have any problems right after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ <hr/> Was initial feeding <input type="checkbox"/> Breast? <input type="checkbox"/> Bottle? Did your baby go home with mother from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ <hr/>
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## General

Do you consider your child to be in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Does your child have any serious illness or medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child had any serious injuries or accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child ever been hospitalized since birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Is your child taking any medications, including vitamins, minerals, or herbal supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Is your child allergic to any medications or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Any allergies to foods or insect bites/stings?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____

## Development

Are you concerned about your child's physical development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Are you concerned about your child's mental/emotional development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Are you concerned about your child's attention span?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Does your child have any problems speaking?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
If in school, how is your child doing in academic subjects?	Explain _____
Has your child shown signs of puberty? <input type="checkbox"/> Yes <input type="checkbox"/> No	If a girl, at what age was her first menstruation? _____

## Past History

Does your child have, or has he/she ever had any of the following.

Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder or kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed wetting (after 5 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any chronic skin problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with eyes / vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma, bronchiolitis, pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any heart problem or heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid or other endocrine problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other significant problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation requiring doctor visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of tobacco products	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please elaborate on any yes responses: _____ _____			

## Family History

Have any family members from mother's and father's side had the following:

Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed wetting (after 10 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained or sudden death (before 50 yrs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure (before 50 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other significant problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please elaborate on any yes responses: _____ _____			

Please let us know who referred your family to us so that we may thank them. \_\_\_\_\_

Who is completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_