MEDICAL INFORMATION SUMMARY ☐ Newborn or ☐ New Patient

Child's Name: Last_____First_____Middle_____

Date of Birth _____ / _____ / _____ Sex _____ Referred by _____

Child

Street Address _____
City _____ State _____
Zip _____
Home Phone _____

Doctor (check one):

☐ Daniel J. Heinmiller, M.D.
☐ Richard A. Kern, M.D.

Mother

Date of Birth ___/___/___ SSN _____
Street Address _____
City _____ State _____
Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____

Father

Date of Birth ___/___/___ SSN _____
Street Address _____
City _____ State _____
Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____

Emergency Contact (other than parents)

Name _____
Relationship to Patient _____
Home Phone _____
Work Phone _____

Guarantor (person responsible for payment)

Name _____
SSN _____
Street Address _____
City _____ State _____
Zip _____
Home Phone _____
Work Phone _____
Employer _____

FAMILY INFORMATION

Mother's Name _____
Father's Name _____
All other children/people living in household:

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please check those diseases which have occurred in the child's siblings, parents, grandparents, cousins, aunts and uncles.

☐ Asthma
☐ Allergies
☐ Anemia
☐ Birth Defects
☐ Heart Disease
☐ SIDS
☐ Cancer (type) _____
☐ Other _____
☐ Strokes
☐ Seizures
☐ Mental Retardation
☐ Sickle Cell Disease

ENVIRONMENTAL HISTORY

Does anyone ever smoke in your house?
☐ yes ☐ no
Does your child drink (circle one)
well, city, bottled, or nursery water?
Was your home built before 1970?
☐ yes ☐ no
List any pets you have:
_____
_____
_____

***** PLEASE ADDRESS ANY CONCERNS WITH ROOMING STAFF OR DOCTOR *****

FLIP OVER ⟶

PREGNANCY HISTORY

Mother's age @ delivery _____ Number of pregnancies _____
Month prenatal care began _____
Prenatal vitamins ☐ no ☐ yes
Illnesses ☐ no ☐ yes *If yes, please list* _____
Accidents / Injuries ☐ no ☐ yes *If yes, please list* _____
Infections ☐ no ☐ yes *If yes, please list* _____
Medications ☐ no ☐ yes *If yes, please list* _____
Ultrasound ☐ no ☐ yes Smoking ☐ no ☐ yes How much? _____
Amniocentesis ☐ no ☐ yes Drinking ☐ no ☐ yes How much? _____

BIRTH HISTORY

Hospital _____
☐ Full Term ☐ Premature -- How early? _____ ☐ Vaginal ☐ Cesarean
Birth weight ____ lbs. ____ oz. Discharge weight ____ lbs. ____ oz.
☐ Breast ☐ Bottle -- Which formula? _____
Complications? ☐ no ☐ yes *If yes, please list* _____
Mother's blood type _____ Baby's blood type _____
Please list any specific concerns you would like to address with the doctor: _____
_____
_____
_____
_____

PAST MEDICAL HISTORY

*only new patients (**not** newborns) need to fill this out*

The child has had:
☐ Asthma
☐ Broken bones
☐ Chicken pox -- age _____
☐ Frequent ear infections -- date of last _____
☐ Pneumonia
☐ Seizures -- date of last _____
☐ Sinusitis
☐ Urinary tract (bladder of kidney) infection

Other illnesses / disorders ☐ no ☐ yes
Surgeries (including ear tubes) ☐ no ☐ yes
Hospitalizations ☐ no ☐ yes
Allergies / reactions to medicines ☐ no ☐ yes
Medicines taken regularly ☐ no ☐ yes

If answered "yes" above, please explain below :
_____
_____
_____
_____
_____

***** PLEASE ADDRESS ANY CONCERNS WITH ROOMING STAFF OR DOCTOR *****