nataloni
Pediatrics P.C.

701 RT. 25A Suite B3
Mt. Sinai, NY 11766
Phone: 631-476-7676
Fax: 631-476-7675

Patient Registration

Legal Name DOB SSN

Legal Name DOB SSN

Legal Name DOB SSN

Father

Legal Name

DOB

SSN

Street Address

City

State

Postal Code / Zip Code

Phone Number

Work Phone

Employer

Mother

Legal Name

DOB

SSN

Street Address

City

State

Postal Code / Zip Code

Phone Number

Work Phone

Employer

Insurance Information

Primary Insurance

Subscriber Name

Member # Group # Subscriber SSN

Claims Address

Policy Type Co-pay amount

Emergency Contact

Name

Phone

Relationship

Pharmacy

Name

City

Phone

Fax

Initial History Questionnaire

Form Completed By ____________________ Date Completed ____________________

NAME ____________________

ID NUMBER ____________________

BIRTH DATE ____________ AGE ____________ M F

Household

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

Name	Relationship To child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live.____
____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?
____
____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?
____
____

Birth History

Birth weight____

Was the baby born at term? _______Early?_______Late?______

If early, how many weeks' gestation?______________________

Did mother have any illness or problem with her pregnancy?
____Yes ____No Explain ______________________________
____

During pregnancy, did mother
Smoke ____Yes ____ No Drink Alcohol ____ Yes ____ No
Use drugs or medications ____ Yes ____ No
What ___________________When ____________________

Was the delivery ____ Vaginal? ____Cesarean?
If cesarean, why? __________________________________

Did your baby have any problems right after birth?
____ Yes ____ No Explain ________________________
____

Was initial feeding ____ Breast? ____ Bottle?

Did your baby go home with mother from the hospital?
____ Yes ____ No Explain __________________________
____

General

Do you consider your child to be in good health? ____ Yes ____ No Explain ______________________

Does your child have any serious illness or medical condition? ____ Yes ____ No Explain ______________________

Has your child had serious injuries or accidents? ____ Yes ____ No Explain ______________________

Has your child had any surgery? ____ Yes ____ No Explain ______________________

Has your child ever been hospitalized? ____ Yes ____ No Explain ______________________

Is your child allergic to any medicine or drugs? ____ Yes ____ No Explain ______________________

Development

Are you concerned about your child's physical development? ____ Yes ____ No Explain ______________________

Are you concerned about your child's mental or emotional development? ____ Yes ____ No Explain ______________________

Are you concerned about your child's attention span? ____ Yes ____ No Explain ______________________

If your child is in school:

How is his/her behavior in school? ____

Has he/she failed or repeated a grade in school? ____

How is he/she doing in academic subjects? ____

Is he/she in special or resource classes? ____

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	____ Yes	____ No	Who ________________	Comments _______________________________________
Nasal allergies	____ Yes	____ No	Who ________________	Comments _______________________________________
Asthma	____ Yes	____ No	Who ________________	Comments _______________________________________
Tuberculosis	____ Yes	____ No	Who ________________	Comments _______________________________________
Heart disease (before 50 years old)	____ Yes	____ No	Who ________________	Comments _______________________________________
High blood pressure (before 50 years old)	____ Yes	____ No	Who ________________	Comments _______________________________________
High cholesterol	____ Yes	____ No	Who ________________	Comments _______________________________________
Anemia	____ Yes	____ No	Who ________________	Comments _______________________________________
Bleeding disorder	____ Yes	____ No	Who ________________	Comments _______________________________________
Liver disease	____ Yes	____ No	Who ________________	Comments _______________________________________
Kidney disease	____ Yes	____ No	Who ________________	Comments _______________________________________
Diabetes (before 50 years old)	____ Yes	____ No	Who ________________	Comments _______________________________________
Bed-wetting (after 10 years old)	____ Yes	____ No	Who ________________	Comments _______________________________________
Epilepsy or convulsions	____ Yes	____ No	Who ________________	Comments _______________________________________
Alcohol abuse	____ Yes	____ No	Who ________________	Comments _______________________________________
Drug abuse	____ Yes	____ No	Who ________________	Comments _______________________________________
Mental illness	____ Yes	____ No	Who ________________	Comments _______________________________________
Mental retardation	____ Yes	____ No	Who ________________	Comments _______________________________________
Immune problems, HIV, or AIDS	____ Yes	____ No	Who ________________	Comments _______________________________________

Additional family history ____
____

Past History

Does your child have, or has he/she ever had:

Condition	Yes	No	Details
Chickenpox	____ Yes	____ No	When ____
Frequent ear infections	____ Yes	____ No	Explain ____
Problems with ears or hearing	____ Yes	____ No	Explain ____
Nasal allergies	____ Yes	____ No	Explain ____
Problems with eyes or vision	____ Yes	____ No	Explain ____
Asthma, bronchitis, bronchiolitis, or pneumonia	____ Yes	____ No	Explain ____
Any heart problem or heart murmur	____ Yes	____ No	Explain ____
Anemia or bleeding problem	____ Yes	____ No	Explain ____
Blood transfusion	____ Yes	____ No	Explain ____
Frequent abdominal pain	____ Yes	____ No	Explain ____
Constipation requiring doctor visits	____ Yes	____ No	Explain ____
Bladder or kidney infection	____ Yes	____ No	Explain ____
Bed-wetting (after 5 years old)	____ Yes	____ No	Explain ____
(For girls) Has she started her menstrual periods?	____Yes	____ No	When ____
(For girls) Are there problems with her periods?	____ Yes	____ No	Explain ____
Any chronic or recurrent skin problems (acne, eczema, etc.)	____ Yes	____ No	Explain ____
Frequent headaches	____ Yes	____ No	Explain ____
Convulsions or other neurologic problems	____ Yes	____ No	Explain ____
Diabetes	____ Yes	____ No	Explain ____
Thyroid or other endocrine problem	____ Yes	____ No	Explain ____
Any other significant problem	____ Yes	____ No	Explain ____
Use of alcohol or drugs	____ Yes	____ No	Explain ____