PEDIATRIC ASSOCIATES INC.

Newborn Registration

Patient Name: _____ Date of Birth: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Parent 1 Name: _____ Date of Birth: _____

Address: _____ Height: _____

Phone Number: _____

Occupation: _____ Email: _____

Parent 2 Name: _____ Date of Birth: _____

Address if different than above: Height: _____

Email: _____

Occupation: _____ Phone Number: _____

Sibling Name: _____ Date of Birth: _____

Sibling Name: _____ Date of Birth: _____

Medical History

Place of Birth: _____ Birth Weight: _____

Type of Delivery: _____ Complications: _____

Surgeries: _____ Hospitalizations: _____

_____ _____

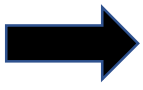
Allergies: _____ Health Problems: _____

_____ _____

Medications: _____

_____

PLEASE TURN OVER TO COMPLETE



Family Medical History

Please indicate if any of the following family members have any health problems including but not limited to diabetes, heart disease, high blood pressure, high cholesterol, asthma, allergies, cancer (specific type), kidney disease, thyroid disease, deafness, seizures, clotting/bleeding disorders, etc.

	Living		History
Parent 1:	Yes	No	
Parent 1 Grandmother:	Yes	No	
Parent 1 Grandfather:	Yes	No	
Parent 1 Aunt(s):	Yes	No	
Parent 1 Uncle(s):	Yes	No	
Cousins(s):	Yes	No	

	Living		History
Parent 2:	Yes	No	
Parent 2 Grandmother:	Yes	No	
Parent 2 Grandfather:	Yes	No	
Parent 2 Aunt(s):	Yes	No	
Parent 2 Uncle(s):	Yes	No	
Cousins(s):	Yes	No	

Home Environment

Type of Home: House Apartment Other

Number of Bedrooms: _____ **Was your home built before 1965?** _____

Water: City Well

Who lives in household? _____

Parents: Married Never Married Divorced Separated

Smokers at home: Yes No **Guns at home:** Yes No

Carbon Monoxide Detectors: Yes No **Smoke Detectors:** Yes No

Pet(s) at home: _____

Type(s): _____