Pediatrics Associates

450 Veterans Memorial Parkway, Building 10, E Prov., RI 02914 (401) 438-6888

Child's Name: _____ Birthdate: _____

Family Info

Parent 1
Birthdate_____Occupation _____

Address _____

Parent 2
Birthdate_____Occupation _____

Address _____

Medical History

Place of birth? _____ Birth Weight? _____

C-section or Vaginal delivery?_____ Complications? _____

Siblings names and dates of birth? _____

_____

_____

_____

Family Health History

Please indicate if any of the following family members have any health problems including diabetes, heart disease, high blood pressure, elevated cholesterol, asthma/ allergies, cancer (specify type), kidney disease, thyroid disease, deafness, seizures, clotting or bleeding disorders, etc.

Mother	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Father	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Siblings	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Maternal Grandmother	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Maternal Grandfather	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Paternal Grandmother	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Paternal Grandfather	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Maternal Aunt	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Maternal Uncle	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Paternal Aunt	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Paternal Uncle	**Alive:**	**Yes**	**No**	**Health problems:**	_____
Cousins	**Alive:**	**Yes**	**No**	**Health problems:**	_____

Home Environment

Type of home: **House Apartment Other** _____

Was your home built before 1965? **Yes No** Water: **City Well**

Who lives in household?_____

Parents: **Married Never Married Divorced Separated**

Smokers at home? **Yes No**

Guns at home? **Yes No**

Smoke detectors? **Yes No**

Carbon monoxide detectors? **Yes No**

Pets at home? **Yes No** If yes what types _____

Does your baby use a carseat? **Yes No**

Will your child be attending daycare? **Yes No**