Pediatric Medicine
52 Timber Lane
South Burlington, VT 05403

Family/Patient History

Date _____

Name: Parent _____ Child: _____ DOB: _____
Parent _____ What does your child like to be called? _____

★★★If this is a prenatal visit, please answer the starred questions.

Birth History:

1. When was your baby born: on time, more than one month early, or late? _____
★ 2. Were there any complications with the pregnancy? _____
3. Were there any complications with the delivery? _____
4. Were there any complications after birth? _____
5. Type of delivery: ❑ Vaginal Delivery ❑ C-Section Place of Birth _____
★ 6. How many other pregnancies have you had? _____
7. At birth what was your baby's: Weight _____ Length _____
★ 8. Is there anything else you would like us to know about your pregnancy or your child's birth? _____

Family History:

★ 1. Has anyone in your family had:

Illness		Relationship	Illness		Relationship
High Blood Pressure	[ ] yes [ ] no		Thyroid Problems	[ ] yes [ ] no	
Heart Attack	[ ] yes [ ] no		Glaucoma	[ ] yes [ ] no	
Mental Illness	[ ] yes [ ] no		Anemia	[ ] yes [ ] no	
Diabetes (sugar)	[ ] yes [ ] no		Seizures	[ ] yes [ ] no	
Stroke	[ ] yes [ ] no		Headaches	[ ] yes [ ] no	
Tuberculosis	[ ] yes [ ] no		Asthma/Allergies	[ ] yes [ ] no	
Cancer	[ ] yes [ ] no		Arthritis	[ ] yes [ ] no	
Birth Defects	[ ] yes [ ] no		Kidney Problems	[ ] yes [ ] no	

★ 2. Are there any other diseases that run in your family? _____
3. Does your child have any current medical problems? _____
4. Is your child allergic to any medications? _____
5. Is your child currently taking any medication? _____
6. Your child's past medical history (illness, surgery, allergies, etc..): _____
★ 7. Is there anything else you would like us to know about your child's health? _____

Please complete other side of form

Lead Risk Assessment:

	Yes	No	Don't Know
1. Does your child live in or regularly visit a house or a daycare center that was built before 1960?	☐	☐	☐
If answer to #1 is "YES" or "Don't Know," please answer questions 1a and 1b.			
1a. Have you noticed peeling or chipping paint in either your child's house or day care center?	☐	☐	☐
1b. Has your child's home or day care center been remodeled or renovated?	☐	☐	☐
2. Does your child have any brothers, sisters, house mates or playmates who are being treated for lead poisoning?	☐	☐	☐
3. Does your child come in contact with anyone who works with lead -- in construction, welding, plumbing, pottery or other trades?	☐	☐	☐
4. Does your child live near a lead smelter, a battery-recycling plant, or other factory?	☐	☐	☐
5. Has your child spent significant time playing with vinyl window blinds? (* Less intimate contact is **not** a risk factor for lead screening.)	☐	☐	☐

Anemia Risk Assessment:

	Yes	No	Don't Know
1. Did your baby weigh less than 3 1/2 pounds at birth?	☐	☐	☐
2. Was your baby born more than one month early?	☐	☐	☐
3. Do you use **low iron** formula?	☐	☐	☐
4. Did you start cow's milk before the baby was 12 months old?	☐	☐	☐

Fluoride Risk Assessment:

	Yes	No	Don't Know
★ 1. Do you have well water?	☐	☐	☐
★ 2. If yes, has your water been tested for fluoride content?	☐	☐	☐

Sleep Position Risk Assessment:

	Yes	No	Don't Know
1. Does your baby (< 1 yr) sleep on his/her back?	☐	☐	☐

Smoke Exposure Risk Assessment:

	Yes	No	Don't Know
★ 1. Are there any smokers in your home?	☐	☐	☐
★ 2. Is your child exposed to smoke outside of your home? (i.e. daycare, relative's house)	☐	☐	☐