Pediatric Staff PLLC
Newborn to 12 years Assessment Form

Child: Last Name: ______________________________ First Name: __________________________ MI: _________

D.O.B.: _____/_____/_____ Gender: _______ Parents: __________________ and ________________________

Name and Address of Hospital where Patient was born:

____

(Address) (City) (State & Zip)

Name of Obstetrician who delivered: ____

Family History

	Age	Health Good, Fair, Poor	Allergies/Environmental/Food	Type of Allergy
Mother				
Father				
Sibling				
Sibling				

****Note: Additional Sibling can be listed on page 2 of this under the additional information setion.**

Other History

Miscarriage(s) _________ Month(s) into Pregnancy ____________________ Cause(s)_________________________

Tuberculosis ________________ TBS Contacts ____________________ Diabetes Convulsive Disease ____________

Mother' Blood Type _________ RH _________ Child' Blood Type _________ Father' (Optional) Blood Type________

Birth and Development

Term ______Delivery Type ____Birth Weight_________ Birth Height ______

Baby' Condition at Birth ____Apgar Score _____________

Condition 1st Week ____

Feeding _________________________ Cyanosis ______________ Convulsions _____________Jaundice ___________

Sat Up __________________ Stood_______________ Walked _________Words _________________________________

Short Sentences ______________________________________First Teeth ________Bladder _______ Bowel ________

Feeding History

Breast ______________________ Formula _________________________________Vitamins _______________________

Primary Drinking Water Supply: ☼Well ☼City/Municipal ☼Bottle / Area Water Fluoride Level: ☼Inadequate ☼Adequate ☼Unknown. Fluoride Supplements: *Topical* ☼Rinse ☼Gel ☼Paste

Systemic ☼Vitamin/Fluoride Supplement ☼Fluoride-Only Supplement. Soft Food __________________ Present Diet ____________________ Feeding Habits ________________ Appetite _______________Likes _______________ Dislikes _______________ Vomiting ________________ Stools ________________ Sensitivity ________________ Hives _________________

Child Illness History

Type	Date	Type	Date
Allergy		Operations	
Appendix		Scarlet Fever	
Asthma		T and A	
Convulsions		Tonsillitis	
Ear Infections		Other:	

Please list additional information below: