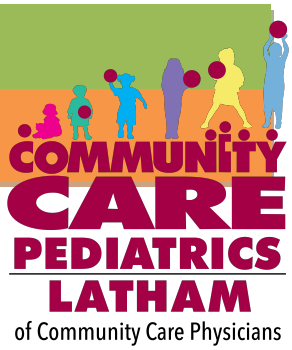
Health Maintenance Questionnaire for:

Newborn



Child's Name: _____ **Date of Birth:**_____ **Time of birth:** _____
Today's Date:_____ **Preferred Pharmacy:** _____

PREGNANCY/DELIVERY:

1. Were there any complications of the pregnancy? _____
2. Was your baby born full term? How many weeks? _____
3. Were there any complications of the delivery/nursery stay? □ YES □ No _____
   _____
4. Birth weight: _____ Birth length: _____ **Type of delivery**: □ Vaginal □ C-section
   Birth hospital: _____

FEEDING/BEHAVIOR:

1. What do you feed your baby? □ BREASTFEEDING □ FORMULA FEEDING □ PUMPED BREAST MILK
   a. How often are you feeding? _____
   b. If formula feeding, what type of formula? _____ How many ounces per feed? _____
2. Any concerns with feeding? _____
3. Is your child taking any vitamins? YES NO
4. Any problems with sleeping? YES NO
   a. Does your child sleep on his/her back? YES NO
   b. Does your child sleep in his/her own crib or bassinet? YES NO

HEALTH HISTORY:

1. Please list all medications your child takes: _____
2. Does your child have any allergies to medications or foods? YES NO
3. Any history of surgeries (ie- circumcision, tongue tie release)? YES NO

Are the child's parents:
□ Married □ Unmarried
□ Separated □ Divorced
□ Other
□ Child adopted/fostered

Does anyone smoke at home or outside the home?
□ Yes □ No

Are there any concerns for violence in the home?
□ Yes □ No

SOCIAL HISTORY:

Who lives at home with your child [including parent(s)]?

Name	Age	Relationship	Occupation

FAMILY HISTORY:

Is there any family history of the following medical problems (in child's siblings, parents, grandparents, aunts/uncles)? If present, please indicate who.

- □ Heart disease _____
- □ Heart attack _____
- □ Diabetes _____
- □ High Blood Pressure _____
- □ Obesity _____
- □ Stroke _____
- □ Asthma _____
- □ Bleeding Disorders _____
- □ Seizures _____
- □ Genetic Diseases _____
- □ Thyroid Disease _____
- □ Psychiatric Disorders _____
- □ Alcohol/Drug Dependency _____
- □ Other _____

CONCERNS:

1. Are there any concerns that you would like to address regarding your child today?
   _____
   _____
   _____

Vaccine Policy Statement

Patient's Name: _____
Date of Birth: _____

We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that vaccines help to maintain healthy children and communities. As medical professionals, **we feel that vaccinating children following the recommended schedule with currently available vaccines is absolutely the right thing to do for all children and young adults**. We firmly believe that:

- Vaccines prevent serious illness and save lives.
- Vaccines are safe.
- Vaccines DO NOT cause autism or other developmental disabilities.
- Vaccines may be the single most important intervention we perform as healthcare providers.

Our policy at Latham Pediatrics is that:

- We follow the American Academy of Pediatrics (AAP) Immunization Guideline and CDC Immunization Schedule
- **We require all patients to be vaccinated**- barring specific medical exceptions (immunodeficiency, etc.)
- If despite our recommendations, you refuse to vaccinate your child, we ask you to find another healthcare provider who shares your views.

Please recognize that by not vaccinating, you are putting your child and others around you at unnecessary risk for life threatening illness, disability, and even death.

ATTESTATION:

I agree with the vaccine policy of Latham Pediatrics. My child will be vaccinated: □ YES □ No

_____ _____
Parent/Guardian Signature Date

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COMMUNITY CARE PEDIATRICS LATHAM
of Community Care Physicians

Patient Authorization

Who is authorized to bring the child for medical care?

I,_____ (name of custodial parent), give permission for_____ to bring my child/children in for medical care.

What can they consent to?

_____ Vaccine Administration

_____ Medication to be given to my child in office

Can another authorized caregiver verbally communicate with us over the phone? If yes who? Relationship? _____

_____

To whom can we release medical information or health forms?

_____ School

_____ Daycare/Babysitter

_____ Camp/Sport Club

_____ Other

This permission will remain in effect until I withdraw permission in written form.

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

Parental Signature _____ Date _____