Dripping Springs Pediatrics
Kathleen Stinson, MD, FAAP and Associates
331 Sportsplex Dr., Suite C
Dripping Springs, TX 78620
512-894-3737 512-894-3738 fax

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ F ☐ M
Your name: _____ Relationship to child: _____
How did you hear about us? _____

SOCIAL HISTORY:
Mother's name: _____ Age: _____ Occupation: _____
Father's name: _____ Age: _____ Occupation: _____
Are parents (circle): married separated divorced or living apart
Please list other persons involved in your child's care (step-parents, grandparents, aunts/uncles, nanny, etc):
_____
Who lives in the home with this child? Number of adults: _____ Number of Children: _____
Please list the names and ages of brothers and sisters:
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Pets: _____ Type of home: ☐ Apartment ☐ Trailer ☐ House
Smokers in Household? ☐ Yes ☐ No Who?_____
Water Source: ☐ City ☐ Well ☐ Bottled ☐ County
_____

MEDICAL HISTORY
MOM'S Pregnancy History: Did patient's mother use or have any of the following issues?

	Y	N	Don't Know	Additional Notes
Medications: Please name:				
Street drugs: Please name:				
Alcohol				
Smoking				
Vaginal infection				
Urine infection				
Other Problems:				

Birth History:

How long was the pregnancy:	
What hospital was the baby born at?	
What was the baby's birth weight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal? ☐Yes ☐ No ☐ Don't know	
Did the baby have any problems? ☐Yes ☐ No ☐Don't know	

MEDICAL HISTORY, continued….

	Y	N	Don't Know	PLEASE GIVE MORE INFORMATION
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have any allergies? To what?				
Does your child get regular dental care?				
Is your child on any medications? Please list:				
Has your child gone to an ER this past year?				
Has your child ever had:				
Ear infections?				
More than 2 strep throats?				
Pneumonia				
Heart problems				
Chickenpox				
Any major illness				
Reaction to any immunization or medications?				
Urinary tract infections?				
Wheezing?				

Family History: Check if close blood relatives have the following and list which family member:

PGF/PGM– paternal grandfather/grandmother MGF/MGM- maternal grandfather/grandmother SIB - sibling
PA/PU – paternal aunt/ uncle MA/MU – Maternal aunt/uncle

Disease	Dad	Mom	Sib	PGF	PGM	MGF	MGM	PA	PU	MA	MU	Disease	Dad	Mom	Sib	PGF	PGM	MGF	MGM	PA	PU	MA	MU
Asthma												Heart attack < 50 yrs											
Sickle cell disease												Urine infections											
Cystic fibrosis												Allergies											
Tuberculosis												High blood pressure											
Kidney infections												Anemia blood issues											
Diabetes												Learning problems											
Hyperactivity												Seizures											
Mental retardation												Emotional problems											
Sudden death												Born w/heart problems											
Birth defects												High Cholesterol											

School / Daycare Behavior History

Child's school _____ Grade: _____

	Y	N	Don't know	Please describe
Does child attend special classes or receive special help?				
Are you concerned about school behavior problems?				
Does your child have problems with:				
Frequent nightmares			N/A	
Difficult to control?			N/A	
Fighting a lot			N/A	
Trouble making friends?			N/A	
Bedwetting or stooling problems?			N/A	
Vision / Hearing			N/A	
Appetite			N/A	

Name of child's previous doctor: _____ Address: _____

Are there any specific issues you would like to discuss with your doctor? _____

_____

Signature of person completing form: _____ Date: _____ Relationship to patient _____