ANGEL PEDIATRICS
717 S Greenville Ave Ste 104
Allen, TX 75002
972-396-1900 Fax 972-396-1901

Name:_____,_____**DOB:**_____/_____/__

PRENATAL HISTORY:

Adopted: Yes No
Mother: Age:____Yo W / B / H / O / Other:_____ Country of origin:_____G____P____A_____
Father: Age:____yo W / B / H / O / Other:_____Country of origin:_____
Place of Bith: Country:_____ City:_____,_____Hospital:_____
Prenatal Care: Country:_____ City: _____,_____Clinic:_____ MD:_____
Mathernal Illness:_____
Medications durring pregnancy:_____

DELIVERY: Vaginal Forceps/Vacum Breach C/Section for:_____
Apgars: 1 minute:_____ 5 minute:_____ 10 minute:_____ Resusc.:_____

MALE /FEMALE Birth Wt:_____ Length:_____FOC:_____ Gest. Age:_____ wks

Number of days in hospital:_____ in NICU:_____ days Ventillated:_____days O2:_____ days

DIAGNOSES AT BIRTH:	TREATMENTS:	PROCEDURES:
1._____	_____	Cicumscision: Y N
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Newborn screen:
½ Pending ½ Normal
½ Abnormal:

Hep B #1:
Date:____/____/____

Hearing screen:
½ Passed ½ Failed

D/C Wt:___Lbs___oz Length:___inches FOC:_____

FAMILY HISTORY:

Cong. Heart D.: _____	M	F	S	B	Other:_____	Alcohol: M F Other:_____	
Aquired Heart D.: _____	M	F	S	B	Other:_____	Smoking: M F Other:_____	
HTN: _____	M	F	S	B	Other:_____	Drug use: M F Other:_____	
MI at age: _____	M	F	S	B	Other:_____	Mental illnesses:	
Stroke at age :_____	M	F	S	B	Other:_____	M:_____	
Seizures:_____	M	F	S	B	Other:_____	F:_____	
Dev. Delay:_____	M	F	S	B	Other:_____	S:_____	
Other Neurol._____	M	F	S	B	Other:_____	B:_____	
Allergies:_____	M	F	S	B	Other:_____	Other Illnesses:_____	
Asthma:_____	M	F	S	B	Other:_____		
Diabetes: TypeI / TypeII_____	M	F	S	B	Other:_____		
Cancer:_____	M	F	S	B	Other:_____		
Sickle Cell D.:_____	M	F	S	B	Other:_____		
Bleeding D.:_____	M	F	S	B	Other:_____		
Kidney D.:_____	M	F	S	B	Other:_____		
Tuberculosis:_____	M	F	S	B	Other:_____		

Social history: Parents: Married
Separated: __/__/__Divorced:__/__/__
Siblings:_____
_____
In the home:_____

DEVELOPMENTAL HIST:

Motor dev.: Normal Delayed
Roll over:_____Mo
Sit: _____Mo
Stand: _____Mo
Walk: _____Mo

Speech: Normal Delayed

CHRONIC ILLNESSES:

	Age of onset:	Date of onset:
1._____	____ Y____Mo	____/____/___
2._____	_____ Y____Mo	____/____/____
3._____	_____ Y____Mo	____/____/____
4._____	_____ Y____Mo	____/____/____
5._____	_____ Y____Mo	____/____/____
6._____	_____ Y____Mo	____/____/____
7._____	_____ Y____Mo	____/____/____