Smita Tandon, MD
DR 2 KIDS
Where kids come first

Patient History

Please complete to the best of your ability. Circle all that apply. Ask the doctor if you have questions or you need help to fill in answers.

Patient's Name	Nickname, if any	Date of Birth

Name of School	City	Grade	Daycare? Y____ N _____

Mom's Name	Contact Number	Dad's Name	Contact Number

Birth History	Name of Hospital, Address			Birth weight ________lbs ________oz
Prenatal History	Age of Mother	No. of times pregnant	No. of children	Abortions or miscarriages

Problems that mom had during Pregnancy	High Blood Pressure Meds	High Sugar	Infections	Medications	Smoke yes no Alcohol yes no Drugs yes no
	VDRL	HBsAg	Group B Strep	Rubella	Other Problems

Past Medical Problems of child		
	Emergency room visits	
	Hospitalizations	
	Chronic Problems	
	Recurrent Problems	

Family History **Any members of the child's family with**	**Disease**	**Mother**	**Maternal Relatives -** grandma etc.	**Father**	**Paternal Relatives -** grandma etc.
	Heart Disease				
	Diabetes				
	Hypertension				
	Cancer				
	Kidney Problems				
	Seizures				
	Asthma				
	Allergies				
	Other				

Under 40 lbs Car Seat in rear Seat Facing Backwards Facing Forwards	**40 – 60 lbs in rear seat Booster Seat?** Yes No	**Over 60 LBS Seat Belt?** Yes No **Which Seat?** Over12y Front Under12y Back

Lives in	Apartment? Which Floor?	Single Family Home Single story / Two Story	
Child Lives with	Mom / step mom / Dad/ step dad / Grandma / Grandpa / Guardian/ sisters/ brothers / cousins	Additional Adults in Home	Additional Children in Home

Sister's Name	**Age**	**Sister's Name**	**Age**	**Brother's Name**	**Age**	**Brother's Name**	**Age**

Sleep Habits	Infant Sleeps on Back Stomach Side	Naps Yes No	Child Sleeps Through Night Yes No
Fire Safety	Smoke Detector In Working Condition Yes No		Fire Evacuation Plan Yes No
Dental Care	Has Teeth Yes No	Brushing Yes No	Last Dental Visit [Date]
Pets	Please list animal, number, indoor or outdoor.		

Comments / Questions?