East Louisville Pediatrics
4171 Westport Road Louisville, KY 40207
6112 Crestwood Station Crestwood, KY 40014

Patient's Name_____Birthdate_____
Last First Middle

Father's Name_____Birthdate_____
Last First Middle

Employment & Occupation_____

Phone_____

Mother's Name_____Birthdate_____
Last First Middle

Employment & Occupation_____

Phone_____

Relative/Friends_____ Phone ( )_____

Please complete as accurately as possible in order for us to provide complete care for your child and fulfill insurance company requirements

FAMILY HISTORY

1. Are both parents in good health? Please circle YES NO
2. Grade in school completed by each parent Mother_____

   Father_____
3. Are parents Married___ Single___ Divorced___ Widowed___ Other___
4. Do both parents live at home? Please circle YES No

5. Please list this child's siblings and their birthdates

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

6. Have this child's parents, grandparents, brothers, sisters, aunts or uncles had any of the following diseases

Anemia	Yes No	Migraines	Yes No
Asthma	Yes No	Sickle Cell Anemia	Yes No
Allergies	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	Mental Illness	Yes No
Heart Attack/Stroke	Yes No	Drug Problems	Yes No
Hepatitis B	Yes No	Alcohol Problems	Yes No
Convulsions/Seizures	Yes No	Inherited Diseases	Yes No
Bleeding Tendencies	Yes No	Sexually Transmitted Disease	Yes No
Cancer	Yes No	AIDS	Yes No
Muscle Problems	Yes No	Bone Problems	Yes No

7. Have any of your children died? Yes No

SAFETY ENVIRONMENT

1. Do you live in a Private Home___ Apartment___ Mobile Home___

   Other_____

2. Are you on city water supply? Yes No

3. Do you know the hottest temperature of the water in your pipes (Maximum 120 degrees)?

   Yes No

4. Do you have a swimming pool or hot tub? Yes No

5. Is there a working smoke alarm on each floor of your house? Yes No

6. Do you and your children always use a carseat/seatbelt when riding in a car or other vehicle? Yes No

7. Are there smokers in your household? Yes No

   Who_____ Packs per day_____

   _____ Packs per day_____

   _____ Packs per day_____

8. Will your child live in or regularly visit a house with peeling or chipped paint built before 1967? Yes No

9. Will your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling? Yes No

10. Does your home include any person being followed or treated for lead poisoning? Yes No

11. Is there an adult in the household who works with lead in either a job or hobby? (Example: soldering, auto body repairs, batteries)?Yes No

12. Do you live near an active lead smelter, battery recycling plant or other industry likely to release lead? Yes No

13. Are there pets in your household? Yes No If yes, what kind_____

14. Are there any firearms in your home? Yes No

15. Is alcohol consumed in your home? Yes No

    If yes, how often_____By whom_____

16. Are there regular medications or illegal drugs used in your home? Yes No

    If yes, how often_____By

    whom_____

17. Has anyone caused you or your spouse physical or sexual harm? Yes No

18. Do you plan to use child care? Yes No

    Daycare? Yes No

    Group care with sitter? Yes No

    Home care with sitter/nanny? Yes No

19. Is there any other matter we should know to care for your child? Yes No