

**SCHWARTZ PEDIATRICS**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**BIRTH HISTORY:**

NAME OF HOSPITAL YOU DELIVERED AT: \_\_\_\_\_

WHICH DOCTOR SAW YOUR BABY IN THE HOSPITAL?      DR. SAM                      DR.DAVE                      OTHER

BIRTH WEIGHT                      VAGINAL                      C-SECTION

TERM                      PREMATURE (# OF WEEKS)

BREAST                      FORMULA

**COMPLICATIONS DURING NURSERY STAY:**                      NONE

\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS HOSPITALIZATIONS: (DATE & DIAGNOSIS)**                      NONE

\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS SURGERIES: (DATE & PROCEDURE)**                      NONE

\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS FRACTURES: (DATE & SITE)**                      NONE

\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS:**                      NONE

\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES:**                      NONE

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\_\_\_\_\_