

Dr. Josephine Ruiz Healy M.D.

Date/Fecha: _____ Name/Nombre: _____ DOB/Fecha de nac.: _____ Age/Edad: _____

Family History/Historia Familiar				Birth History/Hist. del Nacimiento		Feeding History/Hist. de Comidas																					
Mother/Madre _____				Term/Termino _____		Breast/Pecho _____																					
Father/Padre _____				Premature/Prematuro _____		Formula _____																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Siblings/Hermanos</th> <th style="width: 15%;">Age/Edad</th> <th style="width: 15%;">Sex/Sexo</th> <th style="width: 45%;">Health/Salud</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td></tr> </tbody> </table>				Siblings/Hermanos	Age/Edad	Sex/Sexo	Health/Salud	1				2				3				4				Pregnancy/Embarazo # _____		Vitamin Supp/Vitaminas _____	
				Siblings/Hermanos	Age/Edad	Sex/Sexo	Health/Salud																				
1																											
2																											
3																											
4																											
				Vaginal Delivery/ _____		Soft foods added/ _____																					
				Parto vaginal _____		Comidas suaves agregados _____																					
				C-Section Delivery/ _____		Appetite/Apetito _____																					
				Parto por cesarea _____		Stools/Heces fecales _____																					
				Instruments/Instrumentos? _____		Allergies/Alergias _____																					
				Labor length/Duracion _____		Vomiting/Vomito _____																					
Miscarriages/Abortos _____				Other/Otros _____		Idiosyncrasies/ _____																					
Month/Mes _____				Hospital & Doctor _____		Idiosincrasias _____																					
Cause/Causas _____						Other/Otros _____																					
<p>*NOTE: This section refers to immediate family members *A.I.N: Esta seccion se refiere a miembros inmediatos de la familia</p>				(Condition at birth/ Cond. al nacer) _____																							
Allergies/Alergias _____				Weight/Peso _____																							
Diabetes _____				Height/Estatura _____																							
Heart cond./Cond. Cardiaca _____				Apgars/Apgares _____		Vaccines/Vacunaciones																					
Cancer _____				Jaundice/Bilirubina _____		<p>Please provide our office with an updated shot record. Por favor provee la cartilla de vacunacion.</p>																					
HBP/Presion Alta _____				Convulsions/Convulsiones _____																							
Others/Otros _____				Deformities/Deformidades _____																							
				Other/Otros _____																							
Health History/Historial de Salud				Dev. History/Hist. del Desarrollo																							
Gen. Health/Salud en g'ral. _____				Held up head/Levanto la cabeza _____																							
Allergies/Alergias _____				Sat aided/Sento con ayuda _____																							
Chickenpox/Varicela _____				Sat alone/Sento solo _____																							
Colds/Catarros _____				Stood aided/Paro con ayuda _____																							
Measles/Sarampion _____				Stood alone/Paro solo _____																							
Rubella/Rubiola _____				Crawled/Gateo _____																							
Mumps/Paperas _____				Walked/Camino _____																							
Rheum Fever/Fiebre Reum _____				Said words/Dijo palabras _____																							
Pneumonia/Pulmonia _____				Sentences/Frases _____																							
Ear infections/Infecc. Oido _____				First teeth/Primeros dientes _____																							
T&A/Tonsilectomia & Adenoides _____				Other/Otros _____																							
Tonsillitis/Amigdalitis _____				(Habits/Habitos)																							
Scarlet fever/Fiebre escarlantina _____				Sleep/Dormir _____																							
Injuries/Lesiones _____				Naps/Siestas _____																							
Hospitalized/Hospitalizado _____				Play/Jugar _____																							
Other/Otro _____				Other/Otros _____																							

FOR OFFICE ONLY (Do not write below this line)	
HISTORY OF PRESENT ILLNESS	Allergies: _____
Accompanied By: _____	Medications: _____
Chief Complaint: _____	_____
_____	_____
_____	_____



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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Parents Name _____ Birthdate _____

Signature _____ Date _____