Lawrence G. Robinson, M.D. – Pediatric History/Milestones

Patient Name: _____ Date: _____

Patient DOB: _____ Age: _____ (years) _____ (months) Gender: _____

Primary Care Physician: _____ Phone: _____

Other treating Physicians: _____

Patient lives with: ❑ Mother ❑ Father ❑ Step-Mother ❑ Step-Father ❑ Grandparent(s)

❑ Brother(s) ____ ❑ Sister(s) _____ ❑ Other: _____

Birth Weight: _____ Born premature? ❑ Yes ❑ No If yes, how many weeks? _____

Were there any problems during pregnancy? ❑ Yes ❑ No If yes, please explain: _____

_____

Type of delivery: ❑ Vaginal ❑ Cesarean Breech position? ❑ Yes ❑ No

Were there complications with delivery? ❑ Yes ❑ No If yes, please explain: _____

_____

Length of hospital stay after birth (days): _____

Is the patient able to sit without support? ❑ Yes ❑ No If yes, age when first sitting? _____

Is the patient able to walk independently? ❑ Yes ❑ No If yes, age when walked? _____

Has the patient had a Neurologic Evaluation? ❑ Yes ❑ No

If yes with whom: _____

Were the results of the examination ❑ Positive ❑ Negative

Name of person completing form: _____

Relationship: _____ Date: _____