Stanford HEALTH CARE

# University HealthCare Alliance

Name _____

Date of Birth: _____

Primary Care Provider: _____

Please arrive 30 minutes before your appointment time.
Your visit will take approximately one hour to complete.

**Where was your child born?_____**

**Who was your Obstetrician or Nurse midwife? _____**

| **Family History** | **Deceased? At what age:** | **Health problems (As an adult or a child) Including cause of death** |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Sister** | | |
| **Brother** | | |
| **Maternal Aunt** | | |
| **Maternal Uncle** | | |
| **Paternal Aunt** | | |
| **Paternal Uncle** | | |
| **Maternal Grandmother** | | |
| **Maternal Grandfather** | | |
| **Paternal Grandmother** | | |
| **Paternal Grandfather** | | |

| **Social History:** | |
|---|---|
| Siblings: Ages | |
| Parent's Occupation(s): | |
| If applicable: If dual households, which parent has legal medical decision making authority? | |
| If dual households, what is the average time spent at each household? | |
| Pets: | |
| Smoking at home (include smoking outside) | |
| Preferred name of the child | |