



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	