Advanced Foot & Ankle Specialists, P.A.
Jay S. Weingarten, DPM, FACFAS, FACFAOM
Podiatric Physician & Surgeon

Child Assessment Form

Reason for your child's visit:

CHILDS BIRTH/MEDICAL HISTORY:

Please circle *YES* or *NO* to the following questions regarding the pregnancy:

Did you have High Blood Pressure? Yes/No
Did you have any Bladder or Kidney Infections? Yes/No
Did you have any Venereal Diseases? Yes/No
Did you have Diabetes or Sugar in the Urine? Yes/No
Did you have any type of Infections ? Yes/No (If so what type?) _____
Did you take ANY medications, Drugs, and/or Alcohol? Yes/No
(If yes please explain)_____
Did you have any problems with the Labor or Delivery? Yes/No
Was the Pregnancy full term? Yes/No
If not please explain_____
Did your Child experience any problems after Birth? Yes/No
If Yes Please explain_____

Birth Weight_____Lbs./Oz.

What Hospital was your Child Born?_____

SOCIAL HISTORY: (Circle only one)

With Whom does the Child live? Mother Father Both Parents Foster Parent Other

Who lives at home with the Child? (Please provide names and relationship to the child)

1._____4._____

2._____5._____

3._____6._____

Is the Child Current on all immunizations? Yes/No Is the Child in School? Yes/No

Name of Child's School?_____Grade?_____

Name of Child's Pediatrician?_____Phone_____

When did your child last see the pediatrician?_____

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral(who?)_____

Insurance Company_____ Facebook_____ Other_____

Parent's Information:

Mother's Name:_____Date of Birth_____

Employer/Occupation_____Phone_____

ADDRESS *(If different from the child)_____

FAMILY HISTORY: (Please put and X under family members if the medical issues apply)

	MOTHER	FATHER	MOTHERS FAMILY	FATHERS FAMILY	SIBLINGS
ASTHMA					
DIABETES					
HEART DISEASE					
SEIZURES					
SICKLE CELL					
SKIN CANCER					
FOOT/ANKLE PROBLEMS					

Please provide any additional information that may help us care for your Child:_____

_____

_____

_____.

I Hereby Grant Permission to Dr. Jay Weingarten to treat my minor child.

Form filled out by: (Please Print Name) _____

Relationship to minor child: _____

Signature: _____ Date:_____