

DAPHNE MILLER, M.D.
AVRIL SWAN, M.D.
ALEX ZAPHIRIS, M.D.
1286 SANCHEZ ST, SUITE A
SAN FRANCISCO, CALIF. 94114
ph: 415.642.0333 fax 415.642.6233

First Visit Form for Newborns

We look forward to meeting your new baby!. Please leave a message at our office within 12 hours after the birth of your baby so that we can schedule a doctor's home visit as soon as possible. It is important to note that, until our first home visit, the hospital pediatrician or the attending midwife is primarily responsible for important decisions regarding your baby's health.

Please complete the following questionnaire before our first home visit. We have carefully chosen these questions to address all aspects of your baby's health. Your answers will help us to work with you in a way that best meets your family's health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so during your appointment.

Today's Date: _____

Baby's First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth ___/___/___

Phone Number Home (____) _____ Parent's Work (____) _____

Parent's Cell or Pager (____) _____

Where can we leave a confidential message? (circle one) Home Work Cell

Parent's Email Address _____

Mailing Address _____

Emergency Contact Name _____

Relationship _____

Phone Number Home (____) _____, Work (____) _____

Ethnicity: (circle one) Latino Asian/Pacific Islander Black White Native American

Other _____

Person completing this form: _____

Relationship to baby _____

Who referred you to Dr. Miller or Dr. Swan? _____

Please describe the **major expectations** that you have of your family doctor:

Birth Information

Where was your baby born? (circle one) Home Hospital: _____ Other: _____

Age of mother at delivery _____ Age of other parent at delivery _____

Was child born **prematurely**? (circle one) YES NO

If yes, how many weeks early? _____

Were there any problems with the **pregnancy**? (circle one) YES NO

If yes, please explain _____

Was the **delivery** Vaginal or Cesarian Section? _____

Please describe any **problems with the delivery** _____

Please list the names of any **medical providers, dentists and complementary medicine providers** who are also treating your baby:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment	
			From	To

What **medications and remedies** is your child currently taking? This includes over-the-counter medications, homeopathic and herbal remedies and nutritional supplements.

Name	Dose or quantity per day	When did she/he start it?

Does your child have any **ALLERGIES** to medications? (circle one) YES NO

If yes, please describe _____

Family's Medical History Please check the health problems that apply to each family member	c h i l d r r g n p a r e n t	Family's Medical History Please check the health problems that apply to each family member	c h i l d r r g n p a r e n t
Alcoholism/Drug Abuse		High Blood Pressure	
Allergies/Hayfever		HIV, AIDS	
Anemia		Kidney Disease	
Arthritis/Rheumatism		Learning Disabilities	
Asthma		Liver Disease, Hepatitis	
Birth Defects		Mental Illness	
Bleeding Problems		Migraine Headaches	
Cancer or Tumor		Nervous Breakdown	
Colitis or Crohn's		Obesity	
Congenital Heart Disease		Peptic Ulcer Disease	
Depression		Psoriasis, Eczema	
Diabetes		Rheumatic Fever	
Ear infections--frequent		Stroke	
Eczema		Suicide (or attempted)	
Epilepsy, Seizures		Throat infections-frequent	
Frequent Infections		Thyroid Disease	
Genetic Disease		Tuberculosis	
Herpes		Other:	
Heart Disease/Heart Attacks		Other:	

Eating Habits and Nutrition

How many times per 24 hours does your baby breastfeed? _____

OR How many ounces of milk does your baby drink each day? _____

What kind of milk ? (circle all that apply)

Breastmilk Formula Soy milk Other: _____

Would you like to discuss your baby's eating habits and diet? (circle one) YES NO

Daycare and Homecare

Who will care for your baby during the day? _____

At night? _____

Do you have any concerns about your childcare plans? (circle one) YES NO

If yes, please explain: _____

Sleep

Where does your baby sleep? _____

Do you have any concerns about your baby's **sleep**? (circle one) YES NO

If yes, please explain:

Diapering and Bowel Movements:

Do you use cloth or paper diapers? _____

Do you have any concerns about your **baby's bowel movements**? (circle one) YES NO

If yes, please explain:

Does your **baby spend time** with anyone who **smokes cigarettes**? (circle one) YES NO

If yes, please describe: _____

Who are the people, including family members, **who play a very important role in your child's life?**

Name	Relationship to child	Age	Do they live with your child? (yes/no)

Information about the parents:

(Please provide information on both parents, if both parents are involved with the baby)

What are the greatest sources of **stress** in your life? _____

What are the greatest sources of **comfort** in your life? _____

How would you describe your parenting style? _____

Do you have any concerns about **parenting**? (circle one) YES NO

If yes, please describe:

What is/are your **job(s) or occupation(s)**_____

Are you satisfied with your work? (circle one) YES NO

If no, please describe:_____

Is there anything about your **work that negatively affects your mental or physical health**?

What is your current annual **household income**? (circle one)

<\$20,000

\$20,000-\$40,000

\$40,000-\$60,000

\$60,000-\$80,000

\$80,000-\$100,000

\$100,000-\$200,000

>\$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? (circle one) YES NO

If yes, please describe:

Do you have any **concerns** about your current **LIVING** situation? (circle one) YES NO

If yes, please describe:

Do you belong to an **organized religion or spiritual group**? (circle one) YES NO

If yes, please describe:

Is there **any other information** about your child that you feel is important?

Thank you,

Daphne Miller, MD

Avril Swan, MD

Alex Zaphiris, MD